			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H artificate of L	ealth and M D <i>eath</i>		ienez ()	07	36501
			Decedent's Name (First, Middle, Las	it)				2. Date of Dea Month	th Day	Year	3. Time of Death
	hysici /Medic		Linda Carol Nip	per				October		2007	6:00 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. Count	y of Death	
			227 East Avenue	2		Ha	agerstown		Was	hingt	on County
Fu	ineral		Social Security Number     6. Security Number	ex 7. Age □M 2 XF	e (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign aryland
Dir	rector		214-56-0385	UM ZLMF	57 Yrs.			0ct 29	1949	Ma	aryland
pug	<b>*</b>		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside City Limits
fanyl	유명	5	Manuland Washi		,						1X Yes 2 No
the A	288-	Director	Maryland Washin	igton		Hagerstor	W11	1	0g. Citizen of	What Cou	ntrv?
With	o a		227 East Avenu	ıe			21740			U.S.	
deeth	1 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No-		ce - Ameri	can Indian,
paritimote, Mai ylaind 21210000 permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mentel Hygiene.	al', or itar Examine	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Hican, etc.)	Speci	ack, White, ify: Wh	etc. nite
2 P S	natur	Completed	15. Decedent's Ed	iucation	16a. Dece	edent's Usual Occupa	ation	ina	16b. Kind of 8	Business/In	dustry
thin .	N N	P P	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired	)	9	_		
y bed w	5 T	S	12			Homema					Residence
E E	d off avan	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name				
outd Men	ark atic	၉	Edward Earl Be	•				e Mae Si			
2 sh	Tau Tau	0.7	19a. Informant's Name/Relationship (7			ling Address (Street a					
end Health	Thert		Bobbie Mae Bell  20a. Method of Disposition	- mother	20b. Place of Disp	95 Rt. no			1Ship M 20c. Location		
8 jo	o. = 15		1 ☐ Burial 2 🖺 Cremation 3 ☐		cemetery, cre	ematory or other plac	θ)			,	•
it. Pa	rtant njury		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen			urg Cremat		29-2007			Maryland
Departing Department	any ir		Deugla A.	Luny			ern Blvd.	N. Hage	erstown		ral Home 1and 21742
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	nter the mode of dying	g, such as cardiac	or respiratory ari	est,		Approximate Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition	. Cor	onny (a a consequence of):	THEY.	8130451	-			Onset and Death
	edical miner		resulting in death)	Due to (or as	a consequence of):						
LAGI	mile	_	Sequentially list conditions,	b	a consequence of):						
9	ısıt	Jiner	cause. Enter Underlying Cause (Disease or injury	Cité to (or as a	a consequence oil:						
cate be executed	physicien end the burial-translt	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):			_			
ate be ex	sicien buri	a									
ficate	phy s the	edical		, u.							
Physician: The law requires that the death certification	To the Funerel Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of deliv	ery Day Year
thet	deta	y Ph	Part II. Other significant conditions c	ontributing to death be	ut not resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?
duires 1	n sigr	d by	Deabe	fes				1 🗆 Y	es 2□No	3 ☐ Pro	bably 4 ⊠unknown
5 §	shou	Completed						24a. Was	an 24b	. Were aut	opsy findings available
2 a	age 2	E						autop perfor	med? 2 M No	prior to co death? 1  Yes	ompletion of cause of
ב ב	tificat lor, p	0	25. Was case referred to medical				26. Place of Deat			10 162	2 140
ysici	direct	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DOA Othe		ome 5 X esid		ther (Speci	ify)
5 5	After th funeral		27. Manner of Death	28a. Date of Injut (Month, Day	ry 28b. Time Injury		y at	28d. Describe h	ow injury occu	urred	
at die	or: Af of fur	atic	1 Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	1	, , , , , , , , , , , , , , , , , , , ,		Yes 2 □ No				
To the Hospitel or Attending within 24 hours efter death.	Diracto I in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, s c. (Specify)	treet, factory, office		28f. Location (S City or Tow	itreet and Nun n, State)	nber or Rur	al Route Number,
papite	unere! y filleo			ysician: To the best of							
ha He in 24	the Fu	edical	(Check only 2 Madical Examone)	niner: On the basis of and manner sta							
To t	To 1	Σ	29b. Signature and title of certifier			29c. License		1	29d. Date sign	•	
			MMalla	Then		D3	8471		10/3	1/07	>
OH-	3		30. Name and address of person who William Kerns 229				, MD 217	83			
	Sta		31. Date filed (Month, Day, Year)	32 Paristra	ar's Signature	2n	,,	<del></del>			
F	Registi	ar	NUV U Z Z	JULI SEE	in si si	Jan Marie					

			For State	State of Maryland		rtment of H			/	'         /	36502
			Registrar  1. Decedent's Name (First, Middle, Last,		001	imouto or i	Dodin	2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic	al	Helen L	Nielsen				10	26	07	6:20 A M
	Examin	er	4a. Facility Name (If not institution, give:	ice at The L	rike	4b. City, Town, or	Location of Deat	h		Ounty of Death	n 11 0
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. la	"	If Under 1 Year Months Days	If Undered Hrs Hours Min.		h y, Year)	9. Birth	place (State or Foreign
	Director		220-32-7582	71	Yrs.			2/17/1			yland
	tryland thow		10a. State 10b. County		Town or Loc						10d. Inside City Limits
	the Ma	ecto	Maryland Wicomic	o Sai	isbury	10f. Zip Code			10a Citiz	zen of What Cou	1 XYes 2 No
	h with	Funeral Director	1508 Arbutus Driv	ve		2180	4		-	SA	,
	tems	uner		12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (9 an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	. 1	4. Race - Amen Black, White,	
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or tems 23e or 28e-f show event. The Medical Examiner man be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Microed	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1	☐ Yes 2☑ No	Specify:			Specity: W	nite
2-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad		(Give I	ent's Usual Occup	during most of wo	rking	16b. Kir	nd of Business/Ir	dustry
2121	within liene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retired etary	1)		Hom	e Benefi	icial Ins.
	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)			_		me (First, Middle,		Sumame)	
Maryland		Jo	Thomas Morris  19a. Informant's Name/Relationship (Ty	(ne. Print)	10h Mailie	Address (Street		e Hastin ura/ Route Numbe		Town State 7	Code
	# 23 g g		John Nielsen/son	pe, rimy				y, MD 21		rown, State, Zij	0 0000
altimore,	ges 1 ar t of Hea if Item or other		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F		ce of Dispos	sition (Name of	(e)	Date		cation - City or T	own, State
Ē	Pa Int:		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licent	P	ark	Memoria	10/	30/07		lisbury	
Ba	permit. Departr Imports any inji		Local The	trere	5	offoway" Ol Snow	Funeral Hill Rd.	Home Pro, Salisb	fess ury,	ional As MD 2180	ssociation 04
100	Physician   Medical	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a conseque	Tic ence of):	•	_	RCINOU			Approximate Interval Between Onset and Death
68760,	ntificate be ing physicie s as the bur	Medical	IF FEMALE:	d					-2-276 200		
.O. Box	The law requires that the death certificate be executed ten has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes No 9 Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deliv Month	ery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions co.	ntributing to death but not result	ting in the un	derlying cause giv	en in Part I.	23e. Did to		0	the cause of death?
		Completed								24b. Were autoprior to condeath?	opsy findings available impletion of cause of
Vita	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Impatient 2 E	R/Outpatien	3 DOA Oth	or	ath (Check only of Home 5 Resid		COther (See	6.1
n o	ding Phy h. After thi funeral c	on: T	27. Manner of De th		28b. Time of Injury	28c. Injur Wor	y at	28d. Describe h			97
Division of	or Attan	Certification:	2 Accident investigation 3 Suicide determined	28e. Place of Injury - At hom building, etc. (Specify)		M 1 🗆	Yes 2 □ No	28f. Location (S City or Tox			al Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled it	edical Ce	29a. Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examinational and manner stated.	rledge, death on and/or inv	occurred at the tirestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as : place, and due	stated. to the cause(s)
	To the vithin To the complete	Me	29b. Signature and title of certifier			29c. Licens				e signed (Month,	
)	1		18 2			Do	05841	0	10	0-26-	07
	EN		30. Name and address of person who co	coas Col H	23a) (Type, I	Print)	× 1733	SALIS	BUP	y wo	21802
	Sta Registr		31. Date filed (Month Pay Year) 0 2	007 32. Resistrar's Signatu	Henry A	boule			- 1	1	

			For State	State of Marylan		artment of F <i>rtificate of</i>		d Mental Hy				
			Registrar  1. Decedent's Name (First, Middle, Last)		061	Tincate of	Death	2. Date of D	Reg. No. 2	<del>107</del>	3.7 im or 0 ea	<del>13</del>
	Physicia	an		D				Month	Day	Year	8:19	, M
8	/Medic Examin		VELMA PARKE 4a. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De			2007 ty of Death	0:19 /	<u>A</u>
7	Examini	CI	WASHINGTON ADVENT			TAKOMA	PARK		MONTO	GOMERY		
	Funeral		Social Security Number     6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H				lace (State or Fo	oreign
	Director		104-24-2465	<sup>™ 2</sup> 79	Yrs.	IVIOITIIS Days	Tiodis iv	Aug. Z	, 1928	Ports	mouth,	VA
	pu >		Usual Residence of Decedent  10a. State 10b. County	10c Gi	ty, Town or Lo	ocation				1	0d. Inside City L	imits
	aryla shov	<u>-</u>	,							1.	1√_Yes 2[	
	the M	Directo	Maryland Prince Geo	orge's Hy	attsvi	10f. Zip Code			10g. Citizen o	f What Coun	trv?	
	a or	급	630 Sheridan Stree	+ #110		207	02					
	leath	Funeral		12. Was Decedent Ever in U	.S. 13.	Was Decedent of H		(Specify Yes or N	United	ace - Americ	an Indian,	
36	be filed within 72 hours after death with the Maryland Hygiene. id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fur	1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 ☐ Yes ②☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🛣 No		uerto Rican, etc.)		ack, White, hify: Bla		
21215-0036	2 hou atura cal E	ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/Ind	dustry	
212	in 72 in "in Medic	Completed	(Specify only highest grade	e completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working	Ŧ			
212	d with giene gr tha the	mo;	12		Ma	anager			P	rivate		
	e filed al Hygid other vent, th	Be C	17. Father's Name (First, Middle, Last)					Name (First, Midd		ame)		
<u> a</u>	should be filed ind Mental Hygi marked other umatic event, t	2	Joseph Parker				Zo	elma Tur	ner			
Maryland	S S S		19a. Informant's Name/Relationship (Ty			ng Address (Street						
	1 and 2 Health tem 27 l		Theordreia T. Gain			Edwards		ite 1012	, Ade1pl			
0	Pages 1 nent of H int: If iter iny or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	removal from State 1		osition (Name of matory or other pla		1/03/07		-		
altimore,	t. Pag rtment rtant: I		4 □ Donation 5 □ Other (Specify)	1	rt Lin	2. Name and Addre			Brentwo	-	-	
Ba	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licens Charles E. Y.	sung	5	538 Marl	ooro Pil	ke, Fores	stville,			747
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the dea	th. Do not en	ter the mode of dy	ing, such as car	diac or respiratory	arrest,	215	Approximate Interval Betwee Onset and Dea	en
	Physician	ő i	Immediate Cause (Final disease or condition	LUNG	CAR	CINOM	A WI	IH ME	THSIN	12.(7	Onset and Dec	tu i
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	D (	OLON	1 .				
4	Lxammer		Sequentially list conditions,	PERFOR	-7-1 1 E			,		-		
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	JEY L	ATEN	ME	RNIA				
	and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a conser	quençe of);	1,00		, , ,				
9	icate be executed physician and s the burial-transit		L.	Due to (or as a consect HYPOT	Enz	(0N						
68760,		edical		1.								
	death certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn					23d. I	Date of deliv	ery	ļ
P.O. Box	that the death ned by the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		□Ectopic pregnand □ Other <i>(specify)</i> _	ру		-	Month	Day Yea	ar
Ö	t the by the tache	hys	9 Unknown	9∐Unknown								
Division or Vital Records, F	be be	ρ	Part II. Other significant conditions co	ntributing to death but not res	sulting in the o	underlying cause gi	ven in Part I.		d tobacco use co ☐ Yes 2 ☐ No		he cause of d <i>e</i> a bably 4 ∐Unk	
S	w requir been s should	Completed						24a. W	as an 24	b. Were auto	opsy findings ava	ailable
æ	he lav e has ige 2	臣		-		<del></del>		pe	rformed?	prior to co death?	mpletion of caus	
ta	sician: The certificate har rector, page		25. Was case referred to medical				26 Place of	1  Yes		1 ☐ Yes	2 PNo	
>	Physician: r this certifica ral director, p	o Be	eyaminer?	Hospital: 1 Inpatient 2	] ER/Outpatie	ent 3 DOA Ot	her	ng Home 5□Re		Other (Speci	fv)	
0	ding Phys n. After this funeral dii	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time				e how injury occ			
ō	ath.	atio	1 Accident 5 Pending investigation	(Monal, Day Todi)	,,		Yes 2 No					
<u> </u>	er der recto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, s	treet, factory, office	)		n (Street and Nu Town, State)	mber or Run	al Route Numbe	er,
	ital o	Çe										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical		'siclan: To the best of my kn iner: On the basis of examin and manner stated.								
	To the within 2 To the complet	Me	29b. Signature and little of certifier	1 Å		29c. Licer	nse number	C4:	29d. Date sig	ned (Month,	Day, Year)	
			> SAAMWW	M, MD.		D-	547	84	10/5	0/20	OUT	
r	7		30. Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type	Print)	landi i d	84 HOMP	TAI	a DAM	& HO-	7091
	\ 		SHAMO SHAMI  31. Date filed (Month, Day, Year)			012 11DV	C111121	01011	ITIKAN	11118	1 19	J- 11
	Sta Regist		OCT 3 1 2007	32. Registrar's Sign	Sperke	/						

			State of Maryland / Department of Heal  1 - For State Registrar Certificate of Dea		Hygiene Reg. No.	0007 065	0.1
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death Day	2007 09:05	16 4 DM
	/Medic	al	Claire L. Phillips  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Local	Octob ation of Death		2007 09:05 County of Death	РМ
7	Examin	ei	Anne Arundel Medical Center Annapolis			ne Arundel	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 85 Yrs.   1 M 1 M 2 K F 85   1 M 2 K F 85   1 M 2 K F 85   1 M 1 M 2 K F 85   1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1	ours Min. (Month.	Birth Day, Year) /1922	9. Birthplace (State or Fo Country) New Jersey	reign
	yland low at		10a. State 10b. County 10c. City, Town or Location	-		10d. Inside City Li	
	ne Mar Ba-f sl	Funeral Director	Virginia NONE Alexandria			1 <b>X</b> Yes 2 [	] No
	a or 2	Dir	10e. Street and Number 10f. Zip Code 22304			en of What Country? ed States	
	ms 23	rera	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	nic Origin? (Specify Yes or		4. Race - American Indian,	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	y Fui	1 1 Never Married 2 Married 1 ∏ Yes 2 No 1 ∏ Yes 2 No So	pec <i>ify:</i>		Black, White, etc.  Specify: White	
Ö	hours tural", al Exe	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			nd of Business/Industry	-
75	hin 72 e. an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during life. DO NOT use retired)	g most of working	1	,	
7	ed wit	Com	2 Budget Analyst	Advantage of the second second		ral Government	
and	d be fill antal H ced oth	To Be		Mother's Name (First, Mic azel Anna Ka		surname)	
Maryland 21215-0036	should and Me mark	ĭ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and N		-	Town, State, Zip Code)	
Š	and 2 ealth a n 27 is		Ann Claire Phillips/Niece 211 Sir Oliver B				
Baltimore,	it of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		cation - City or Town, State	
<u>#</u>	artmer ortant: injury	1	4 □ Donation 5 □ Other (Specify) Kalas Crematory  21. Signature Service Licensee 22. Name and Address of	10/25/2007	1 - 4 - 6	water, Maryland as Funeral Home	
B	permi Depar Impor any ir	0 0				as runeral nome ater, MD 21037	
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DIAL 1	NEA	EASE	
8760,	cate be executed ohysician and the burial-transit	ical Exa	that initiated events c.  resulting in death) Last Due to (or as a consequence of):  d.				
P.O. Box 68	death certific e attending p d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 D No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		_ 2	3d. Date of delivery Month Day Yea	ır
	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in		Did tobacco us	se contribute to the cause of deat	
or Vital Records,	The law ate has b page 2 sl	Completed		a	Was an autopsy performed?	24b. Were autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ No	ilable e of
	g Physiclan: The string of this certificate eral director, page	To Be	examiner? 1   Yes   2   No	Place of Death (Check of Place of Death (Check of Place)  1 Nursing Home 5 Fig. 128d. Description	4		
Division	r Attending I er death. rector: After by the funer	Certification:	1	28f. Location	on (Street and Town, State)	d Number or Rural Route Number	r,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cer	29a. Certifier  (Check only (Check only a property)  1 Dertifying Physician: To the best of my knowledge, death occurred at the time, described by the control of the property				
	To the within 2 To the complex	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License nun	mber	29d. Date	e signed (Month, Day, Year)	
	L S F O	2	1 Howard Doo	63145	10	0/25/07	
' 	86		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ARVIND DESAI 10440 Lift	He Patr	Kul	+ PKuy Colu	Mu
1	Sta Registi		33. Registrar's Signature				

			For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death	Mental Hygien	,	36505
	F		Decedent's Name (First, Middle, Last	st)		2. Date of Death		3. Time of Death
Н	Physici /Medio		JAMES H.	PLATT		OCT. 27	2 2007	3:30p.M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea		c. County of Deat	
			PRINCES GEOR		CHEVERLY		RINCES	GEORES
	<ul> <li>Funeral</li> </ul>		5. Social Security Number 6. S	M	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Mir		9. Birti	hplace (State or Foreign untry)
	Director		577 58 70/4 1 Usual Residence of Decedent	X <sup>M</sup> <sup>2</sup> □ F 63 Yrs.		10-27-17	143 WA	SH DC
	/land		10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mar-	ţċ	1) C	WASHIN	GTUN, DC			1 Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Co	untry?
	23a	Ta I	2957 MILLS		20018		USA	
	er de	Funeral	11. Marital Status		Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, White	
36	thin 72 hours after death with the Maryland e. en "naturel", or Items 23a or 28a-1 show Madical Examirat must be naillisd at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: BZ	ACK.
21215-0036	2 hou		15. Decedent's Ed	ducation 16a. Dece	dent's Usual Occupation	16b.	Kind of Business/	
215	within 72 ene. then 'nai	pie	(Specify only highest gra	College (1-4or 5+) (Give life.	kind of work done during most of wi DO NOT use retired)		towar.	
	X 6 2 3	Completed	124RS.	MAI	NTANCE		NIVERS	174.
Ind	tal Hydra oth	Be	17. Father's Name (First, Middle, Last)			arne (First, Middle, Maide		. /
yla	1 Ment 1	5	JOSEPH TIAT	To Girel A Constant		M. JA		
Maryland	s 1 and 2 should be filled if Health and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (		ng Address (Street and Number or F 5036 -124k S7			
	Health tem 27 other tr	1	20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Location - City or	
OE.			1 ABurial 2 □ Cremation 3 □ 4 □ Dopation 5 □ Other (Specific	Removal from State	matory or other place)	5-2007 B	OFATTIN	an an
Baltimore,	그분운공 .		21. Signature of Funeral Service Licer	2	2. Name and Address of Facility	5 FUNGE	1 Hen	E
m	Depa Impo any le		Verent Sur		COLN CEM. 11- 2. Name and Address of Facility NO 1015-1246 ST	NE WAS	HDC.	20017
100			3a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not en one cause on each line.	ter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
	Physician		Ummediate Cause (Final disease or condition	FATAL CARDIA	C ARRHYTHI	MIA		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
В		e	Sequentially list conditions,	b. Due to (or as a consequence of):				
	nted nsit	in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 to (0. 20 a consequence of).				
ć	cate be executed obysician and the burial-transit	Examin	that initiated events resulting in death) Last	c				
8760	cate be physicia the bur		(	d				
9		Med	IF FEMALE:					
Вох	death certific e attending pl ed for use as I	an/	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of del Month	ivery Day Year
0.	0 0 2	Physician/Medical	1 Yes 2 No	4☐ Pregnant at time of death 5 [	Other (specify)		WOTH!	Day (da)
<u>α</u>	requires that the de teen signed by the a hould be detached			ontributing to death but not resulting in the u	Inderlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Vital Records,	sign d be	d by				1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
CO	s been s shoul	lete				24a. Was an	24b. Were au	itopsy findings available
Re	9 4 9	Completed				autopsy performed? 1 ☐ Yes 2 🗶 N	prior to death?	completion of cause of 2 □ No
ital		a l	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 🗷 Neath (Check only one)	10 103	2010
> -	\$ <u>∞</u> 5	To B	examiner? 1 ☐ Yes 2 💢 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spe	cify)
פע	ing Ph After th Ineral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not b		M 1 Yes 2 No			
Division of	al or Attend after death   Director: / d in by the f	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta		irai Houte Number,
_	Hospital 24 hours 6 Funeral I		29a Certifier 1 Certifying Ph	I systetian: To the best of my knowledge, dest	h occurred at the lines, date and blace	te and due to the cause	(s) and manner ar	stated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai	(Check only 2 Medical Exam	iynician: To the best of my knowledge, dear niner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occ	curred at the time, date a	nd place, and due	to the cause(s)
	To the To the complet	M	29b. Signature and little of certifier		29c. License number	i i	Date signed (Monte	
-			· MY		D55220	) 10	12712a	7-
0	(2)	1	30. Name and address of porson with	completed cause of death (Item 23a) (Type	Print) D5522Ch	, 1		
			31 Date filed (Month Day Year)	IN MO 3001 H	ospur Ch	everly h	10 30.	+75
7 1	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 1 2007	32. Registrar's Signature		J		
			/					

			1 - For State Registrar	State of N	/larylan		artment tificate			and M	lental Hyg	giene Reg. N2	007	36506
	Physici	an	1. Decedent's Name (First, Middle	•	D - + -						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Herbert  4a. Facility Name (If not institution)	Lee	Pete	rson	4b. City, T	Town or	Logation		October 2	<del>-</del>	ounty of De	6:10 P M
	Examin		Ft. Washington Nursi	-			Ft. V			n Death			ince Ge	
	Funeral		5. Social Security Number	6. Sex 7. /		last birthday)	If Under	1 Year	If Under		8. Date of Birtl	h	9. B	rthplace (State or Foreign
	Director		268-18-5702	1 <b>√</b> M 2□F	95	Yrs.	Months	Days	Hours	Min.	Jan. 25,	1912		Ohio
	put *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f eho	ō	D.C. Nor	ie		shingto								t <del>XX</del> Yes 2 □ No
	the 28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What C	Country?
	h with	a D	2715 31st Street S.	E. #580			2	20020					USA	
	ems s	Funeral	11. Marital Status	12. Was Decede Armed Force	e?		Was Decede	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14	Race - An	nerican Indian,
36	or It	by Fu	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 1 Yes 2 [ If Yes, Give Year or Date		<del>1</del> 3-	1 ☐ Yes 2		Specify:			1	pecify: W	
00	i within 72 hours after death with the Maryland liene. I then "natural", or Hems 23e or 28e-f ehow It e Medical Exama ar must be I celified at		15. Decedent		s: 1740	16a. Dece	dent's Usual	l Occupa	ition			16b. Kind	of Busines	s/Industry
215	within 72 iene. than "na	plet	(Specify only highes Elementary/Secondary (0-12)		vr 5.1)	(Give	kind of worl DO NOT us	k done d	urina mos.	t of work	ing			
21	ad with giene.	Completed	Clotheritary/Oscoridary (0 12)	4 0011095 (1 40		Electr	onic Er	ngine	er			Fede	eral Go	vernment
nd	be filed ital Hygi of other event,	Be	17. Father's Name (First, Middle,								e (First, Middle,		umame)	
Maryland 21215-0036	2 should be 1 and Mental I ie marked of reumatic eve	은		erson		405 14-15		/64	Mary			Setty	Taura Canan	Tin Code)
Mai	d 2 st th and t7 ie n		19a. Informant's Name/Relations!  Larry Peterson / S				-	•			a <i>l Route Numbe</i> Igton, Mar	•		
ē,	is 1 and 2 should of Health and Meritem 27 is marke other treumatic		20a. Method of Disposition		1 -	Place of Dispo	sition (Nam	ne of	- 1	100	Date			or Town, State
E O			1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation  5 ☐ Other (S)	_	T <del>O</del>	fast Ohi				10/31	/2007	Belfas	st, Ohio	0
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature uneral Service	icensee		22	2. Name and	d Addres	s of Facilit	y Geo	rge P. Ka	las Fu	meral 1	
<u> </u>	8258		ANF.	alas fi							n Hill, M		nd 20	745
	Pnysician /Medical Examiner	er	23a. Part Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a Due to (or		tte, w juence of):			Sci					Approximate Interval Between Onset and Death
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	edical Examiner	cause. Enter Underlying Cause (Disease or ritiging that initiated events resulting in death) Last	cDue to (or d	as a conseq	juence of):					- 10-			
.O. Box	at the death certific by the attending p tached for use as I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 ☐ Feta at time of d	l death 3	∃Ectopic pre ∃ Other (spe					23	d. Date of c Month	lelivery Day Year
ds, P	ires that signed to it be det	by	Part II. Other significant condition	ns contributing to deat	n but not res	ulting in the u	nderlying ca	ause give	en in Part I	•	23e. Did to	2		to the cause of death?  Probably 4 □Unknown
SOr(	w requir been si should	etec					_				24a. Was	- 1		
Vital Record	The ate h	Completed									autor perfo 1  Yes	osy rmed? 2 No	prior t death	autopsy findings available o completion of cause of ? es 2 \( \sqrt{N} \)
Σ	Physicien: this certificaral director, p	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No	Hospital: 1   Inpa	atient of	ER/Outpatier	nt 3□ DO	Δ Othe			h <i>(Check only d</i> ome 5 ☐ Resid		Other (6)	necify)
of		H-06	27. Manner of Death	28a. Date of I		28b. Time o		8c. Injury Work	at	_	28d. Describe I			oodily)
ior	Attending I r death. ector: After by the funer	atlo	1 Natural 5 Pendin 2 Accident Investig	ation	Day 16ai)	Injury	М		Yes 2□	No				
Division	al or Attends after death	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 286. Place of	Injury - At h etc. (Speci	ome, farm, sti fy)	reet, factory	, office			28f. Location (3 City or Tox		Number or	Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Diruccompletely filled in the	edical (	29a. Cartifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basis	s of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	ie, date an pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	and manner place, and d	as stated. iue to the cause(s)
	To the To the To the Complet	Σ	29b. Signature and title of certifie		,		290	. License	number			29d. Date	signed (Mo	onth, Day, Year)
11			· Welfan 6	· 1 amo	19			D3	¢ 21	26		00	TURA	26,2007
12	50/11		30. Name and address of person	who completed cause of	of death (Iter	n 23a) (Type,	Print)	istn	, Ro	pd.	Fatw	Ashin	stry 1	26,2007 nonford.
:	Sta Registr		31. Date filed (Month, Day, Year)	San Reg	strar's Signa	Jak .								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene,

1- State and #26 per PHYS 10-29-2007 CNM reflects of Death CNM Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Giuseppe Pitruzzella October 25, 2007 10:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 997 Heather Ridge Drive Frederick Frederick 8. Date of Birth (Month, Day, Ye Nec 24, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign Country Campobello 1941 di Licate (AG) 7. Age (In yrs. last birthday) **Funeral** Days Year Months Hours Min. 1 M 2 □ F 65 Yrs. **Director** 111-42-1800 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pennsylvania Berks Sinking Spring 1 ☐ Yes ŽĂ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 8 Rosemary Drive 19608 Italy Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ir than "natural", or iten the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white If Yes, Give Year or Dates: ¥¥Widowed 4 □ Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Restauranteur other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Antonio Pitruzzella Salvatrice Ragusa ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Rosemary Drive, Sinking Spring, Pennsylvania Antonio Pitruzzella - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Francofonte Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Francofonte, Italy 11-9-2007 4 Domation 5 ☐ Other (Specify) permit. 21. Signat ure of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland an Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final ttherscleratio **Physician** ears disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform autopsy After this certificate Ke pronic Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Shesidence 6 HOther (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) anger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No nours after death. death. M 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 29a. Certifier 🛮 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

9 2007

Dar

1/ain

31. Date filed (Month, Day, Year)
OCT 2

ME

gistrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT. 25, 2007 THERESA MAE PRATHER 1:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital MONTGOMERY Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Dec. 6, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 89 1 □ M 2 🔀 F Maryland 579-44-1858 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 25 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15201 Elkridge Way, #3E 20906 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Black Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Woodward & Lothron Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store yr 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Duvall Ida Sellman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (196) 20906 19a. Informant's Name/Relationship (Type. Print) Theodore W. Prather (Husband) 15201 Elkridge Way, #3E, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Nat'l Mem. Park 11/3/07 Laurel, MD 4 Dona fin 5 Dother (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 23a. Part1. Enter the disease shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cholangiocarcinoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a sequenced to the cause of the cau Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【\*Unknown End State Renal Disease 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 X No

Physician /Medical Examiner

executed

Box 68760, certificate be

P.O.

Division or Vital Records.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

<u>\$</u>

Completed

Be

၉

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

death v

72 hours after

d 2 should be filed within 7 in and Mental Hygiene.
7 is marked other than "

3.1 and 2.st of Health ar if Item 27 is

Department of Hear Important: If item "any Injury

Baltimore, Maryland 21215-0036

Examine Physician/Medical þ Completed

nding physician and use as the burial-transi use as atten for u signed by the a d be detached f page 2 s Be P Certification: s after dea... al Director: After completely filled in by

peen

has

certificate

After

5

To the Hospital within 24 hours a To the Funeral C Hospital

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

Hospital: 1 ☑ npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28c. Injury at Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 XNatural

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

29b. Signature and title of certifier

D52261

29d. Date signed (Month, Day, Year) 10/25/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.Alan R. Segal, 1517 Hugo Circle, Silver Spring, MD 20906

State Registrar

Medical

31. Date filed (Month, Day, Year) OCT 30 2007 32. Degistrar's Signature

State Registrar

DHMH 17 Rev 1/2001

the Hospital

ပ္

within 2

with the Maryland

death v

filed within 72 hours after

Pages 1 and 2 should be

the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

FARROKH 31. Date filed (Month, Day, Year) OCT 2 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOHRABI

29b. Signature and title of certifier

lan & from

M.D.

2001

DØØ 6523Ø

29d. Date signed (Month, Day, Year)

			Please						. Ensure A	-		egible.		
		For State		State o	f Maryla		•		lealth and N	lental Hy	giene			
		Registrar	- (First Stinfelle I	ent)			Cert	ificate of	Death	2. Date of De	Reg. No.2	007	3.5	510
Physic	ian	1. Decedent's Nam		erick						Month ,	Day	Year	7 98	49AM
/Medi		Larry  4a. Facility Name (/			mber)			4b. City. Town, o	r Location of Death	Octob		Ounty of Dea	, ,	1 117
Exami	ner	Doctor's	_					Lanh					Georges	;
Funeral		5. Social Security N		Sex		yrs. last birti		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Bi	rthplace (State	or Foreign
Director		535-38-8		1 <b>X</b> M 2□F	68		Yrs.	Worters Days	Tiodis Will.	Sept.3	3, 193	39 No:	rth Dak	ota
and		Usual Residence of 10a. State	10b. County		10c.	City, Town	or Loca	ation					10d. Inside	City Limits
Maryl f sho	Ö	MD	Prince	Georges		Bowi	e						1 □ <b>X</b> Y∈	es 2□No
r 28a	Director	10e. Street and Nu						10f. Zip Code			10g. Citize	en of What C	country?	
th witl 23a o ist be	ā D	13207 I	dlewild 1	Drive					20715			USA		
ems er mu	Funeral	11. Marital Status		12. Was Dece Armed Fo	edent Ever i	n U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	0- 1-	4. Race - Am Black, Wh	erican Indian, ite, etc.	
s afte	by Fi	1 ☐ Never Marr 3 ☐ Widowed	ied 2K Married	1 X Yes If Yes, Giv Year or D		9-'80	11	☐ Yes 2X No	Specify:			Specify: W	nite	
hour	ed b	3 Widowed	15. Decedent's B		ates.	16a	Decede	ent's Usual Occup	pation		16b. Kin	d of Busines	s/Industry	
nin 72 Sin na Medik	plet	(Spec	cify only highest g	rade completed) College (	I-4or 5+\	-11	(Give ki	ind of work done O NOT use retired	during most of wor d)	king	_		Science	s
d with giene er tha	Completed	12	mary (0-12)	College (		C	ompu	iter Spe	cialist		Co	rpora	tion	
tal Hy	Be	17. Father's Name		st)				!	18. Mother's Nan			Surname)		
y la ould l Men narke	ဥ	Louie R							l	Bickle				
VICAL d 2 sh h and 7 Is m traum		19a. Informant's N	ame/Relationship oerick/	, ,,		1		,	and Number or Ru ld Drive				Zip Code)	
Healt Healt em 2		20a. Method of Dis		MILE	20			ition (Name of atory or other place		Date			r Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at anotes.			XCremation 3   5 □ Other (Spec						сө) atory 10/	28/2007	Ale	exandr	ia, VA	
mit. F sartme oortan Injur		21. Signature of Fr							ess of Facility Rob				_	ie -
Depari Impor		16	luc	3					apolis Ro					
		23a. Part1. Enter t shock, or hea	the disease, or con art failure. List onl	mplications that of your one cause on e	aused the cach line.	death. Do n	ot ente	r the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approxim Interval E Onset an	late letween
Physician		Immediate Cause disease or condition resulting in death)	(Final on	_a.	reto	estu	Dr	Lun	t Cur	OR			Oliset all	u Deam
/Medical Examiner		resulting in death)		Due to	(or as a con	sequence	1		Ja	. 0				
	i i	Sequentially list ou if any, leading to in	nditions nmediate	b	(or as a con	sequence of	(d. 10 of):	ry	allu	16			-	
uted d ansit	Examiner	if any, leading to in cause. Enter Under Cause (Disease or that initiated events	erlying injury	0	He	100 h	ems	Singl	1					
e exec ian an urial-tr	Exa	resulting in death)	Last	Due to	(or as a con	sequence o	of):	-210-1						
eath certificate be executed attending physician and for use as the burial-transit	ical		•	d				· · · · · · · · · · · · · · · · · · ·						
ertific ding p	Mec	IF FEMALE:		23c. If ves, ou	toomo of ar	oanana.								
eath o	cian	23b. Was deceder in the past 12	months?	1 ☐ Live I	pirth 2 □ I	Fetal death		Ectopic pregnanc Other (specify)	y		2	3d. Date of d Month	elivery Day	Year
the d	Physician/Medica	1 ☐ Yes 2 9 ☐ Unknowr		9□Unkn										
s that med b	by Pi	Part II. Other signi	ficant conditions	contributing to d	eath but not	resulting in	the und	derlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute	to the cause o	of death?
en sig										1	Yes 2	No 3□	Probably 4 [	∐Unknown
law r as be	plet									24a. Wa aut	opsv	24b. Were prior to	autopsy finding completion o	gs available f cause of
The cate h	Completed									per 1□ Yes	formed? 211No	death1 1 ☐ Ye	?	
iclan certificector,	Be	25. Was case refe examiner?	/	Hospital: 4 -					26. Place of Dea					
Phys rthis	<u>۱</u>	1 ☐ Yes 2 27. Manner of Dea		28a. Date		2 ER/Out	tpatient Time of	3 DOA 28c. Inju	4 LI Nursing H	ome 5 ☐ Res 28d. Describe			pecify)	
th. :: Afte	ţi	1 Natural 2 ☐ Accident	5 ☐ Pending investigation		th, Day Yea	ar) Ir	njury		rƙ? ]Yes 2∐No					
Atternation of the part of the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d Zoe. Flace	of injury - /	At home, fai	rm, stre	et, factory, office		28f. Location	(Street and own, State)	Number or	Rural Route N	umber,
Ital or ral Dil	Certification:													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)		aminer: On the b	asis of exar				ime, date and place opinion, death occi					e(s)
o the ithin 2 o the omple	Med	29b. Signature and	title of certifier	and mar	ner stated.			29c. Licens	se number		29d. Date	signed (Mo	nth, Day, Year	.)
<b>⊢ ≶ ⊢</b> Ō		1	101	4				midi	1) 6092	5	10	12610	07	
		30. Name and add	ress of person wh	o completed cau	se of death	(Item 23a) (	Type, P	Print)						
St CH		Elizab		sika	575	ma	ins	street,	Suite 3	151, Lo	lure	1, mo	. 2070	57
St Regis	tate trar	31. Date filed (Mon	nth, Day, Year) CT 2 9 2[	107	Registrar's S	Signature	1							
			- 1 N U Z	101		A.	One	400						

07-08393 Okhee Ryu

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate Registrar	110	eg. No. 2007 3651
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last)	Date of Deal     Month     October 2	
viedicai Examinei	OKHEE RYU  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	14330 Travilah Road	Gaithersburg	Montgomery
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year   If Under 24Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director	638 42 8511 1 M 2XF 41	Yrs. Months Days Hours Min. APRII	29,19 Country) S KOREA
è	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
T 00 as	NO MODELL	POTOMAC	1 X Yes 2 No
daryland 28a-f show any <u>d at once.</u> ector	10e. Street and Number	10f. Zip Code	0g. Citizen of What Country?
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once. eed by Funeral Director	13928 RIDING LOOP DR	20878	S. KOREA
r death with or items 23 must be no	11. Marital Status 1 Never Married 2 X Married Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc.
r deat or ite	1 Yes 2 X No	Yes 2 X No specify:	Specify: ASIAN
urs afte	l or Dates:	edent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
G = 5	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use retired)	
vithin vithin ene.	12 5 SC	ENTIST	US GOVT
215-00 be filed wit mital Hygien riked other ent, the MBB Be Con		18.Mother's Name (First, Middle, IDO NAM CH	UNG
	HAN SU RYU  19a. Informant's Name/Relationship (Type, Frant)  19b. M	ailing Address (Street and Number or Rural Route Nur	
e, MD I and 2 sho Health and item 27 is r traumati		3928 RIDING LOOP DR N	
ore, stan Stan Stan Stan Stan Stan Stan Stan S		sposition (Name of cemetery, Date or other place)	20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	4 Doction Other Specify: METROI	POLITAN 11/3/07	
Baltimo permit. Page Department o Important: injury or oth	21. Signature of Funeral Service Licensee	22. Name and Address of Facility CHARLES	HINDS FUNERAL SERV
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not en	L2303 KAYAK DR UPPER Inter the mode of dying, such as cardiac or respiratory arr	est, shock, or heart Approximate Interval
Medical.	failure. List only one cause on each line.  Immediate Cause (Final disease a. Asphyxia		Between Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):		
<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated	·	
xecuted 1 and 2 transit	events resulting in death) Last  Due to (or as a consequence of):  d.		
<u> </u>	UNPENDED AMENDED		
			23d. Date of delivery
ox 687 eath certific attending 1 for use as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 pregnant at time of death 5	Fetal death 3 Ectopic pregnancy  Other (Specify)	Month Day Year
Box 68 e death certif the attending ed for use as	1 Yes 2 No 9 V Unknown g Unknown	Other (Specify)	
P.O. BOX		and discontying duality great in the control	obacco use contribute to the cause of death?
ords, P w requires t us been sign should be d		1Ye	s 2 No 3 Probably 4 Unknown  an 124b, Were autopsy findings available
Records, The law requires frate has been sig		auto	
tal Rec		1 ✔ Yes	
sician:	examiner?	26.Place of Death (Check only one)	Residence 6 V Other: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should bertification: To Be Completed	1 V Yes 2 No	e of Injury 28c. Injury at Work? 28d. Describe	how injury occurred
Division ospital or Attending nours after death. neral Director: After filled in by the function: Certification:	1 Natural 5 Pending FOUND: FOUND FOUND 1042 his	1 163 2 4 140	nd hanging
Division pipial or Attentous after death eral Directors filled in by the	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	street, factory, office building, etc. 28f. Location (	Street and Number or Rural Route Number, City State)
Hospital 24 hours : Funeral tely filled		14330 Travila	ah Road, Gaithesburg, Md
Division of Vital Records, P.O. Box 687.  To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician)	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner; On the basis of examination and/or inve	occurred at the time, date and place, and due to the cau stigation, in my opinion, death occurred at the time, date	se(s) and manner as stated.  and place, and due to the cause(s)
To with To com	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	line IZ.	O.C.M.E.	October 29, 2007
	30. Name and address of person who completed cause of death (Item 23a)	0	
- (0)	Ana Rubio MD. Assistant Medical Examiner 111 Per 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nn Street, Baltimore, MD 21201	
State Registra			
	The state of the s	Whe	

100 1/2001 OCME 2006

CCME

ORIGINAL

1

DHMH 17 Rev 1/2001

State Registrar FRANCIS KHOO, MD

OCT 26

2007

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

30263

10-52-0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, MD ZOOMEMORIAL AVE, WESTMINSTER, MD 2115

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October DAVID QUEARY RICHMOND 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGES DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours **X** M 2□ F 243 62 6161 AUG. 28, 1942 NORTH CAROLINA 65 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes XX No PRINCE GEORGES MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 UNITED STATES 11409 WAESCHE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes XX No Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME DELIVERY MANAGER WASHINGTON TIMES 1+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ARLEEN MASON WALTER RICHMOND, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11409 WAESCHE DR. MITCHELLVILLE, MD 20721 MERLE RICHMOND / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 11/05/2007 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND M 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shop, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) METASTATIC Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

s 1 and 2 should be filed wi f Health and Mental Hygier item 27 Is marked other th

permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tra

burial-transit attending physician for use as the buria ed by the detached signed by t

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Examine Physician/Medical Completed after death.

Director: After this certifical in by the funeral director, Be 2 Certification:

Division or Vital 0 within 24 hours a To the Hospital

0

State

26. Place of Death (Check only one)

9	Hosp	oital: 1 Inpatient	2 🗆	ER/Outpatient	3 🗆 1	DOA	Other:	4 ☐ Nursing H	lome	5 Residence	6 □Other (	Specify)
5 ☐ Pending investigation		28a. Date of Injury (Month, Day Y	ear)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes	2 □No	28d.	Describe how inj	ury occurred	

6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

determined

201770

D. 680x68 7500 HAN OUEK

31. Date filed (Month, Day, Year) OCT 3 1 2007

29b. Signature and title of certifier

1 Yes 2 Ne

27. Manner of Death

1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

Wedical

32. Registrar's Signaty

Registrar

			1 - For State Registrar	State of	of Mary		artment of Fertificate of			giene Reg. No.2 () (	)7	36514
	Dhomini		1. Decedent's Name (First, Midd	le, Last)					2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Joseph		nior	Ritte			October :			11:29 А м
	Examir	er	4a. Facility Name (If not institutio		ımber)		4b. City, Town, o	r Location of Dea	th	4c. County	_	rge!s
	Funeral		8601 Allentown Ros  5. Social Security Number	6. Sex	7. Age (II	n yrs. last birthday	If Under 1 Year	If Under 24 Hrs	8. Date of Birth	5	O Dieb	alana /Ctata as Familia
	Director		232-03-6877	<b>¥</b> ⊠M 2□F	91	Yrs.	Months Days	Hours Min	Dec. 14,	1915	west.	Virginia
	pud *		Usual Residence of Decedent  10a, State 10b, County	,	10	Oc. City, Town or L	ocation					10d. Inside City Limits
	Maryla f sho	ō		e George's		Ft. Wash						1 ☐ Yes 2 📆 📢 o
	1 the 1	Je C	10e. Street and Number	3 000180 0		TOT WOLLT	10f. Zip Code			10g. Citizen of W	/hat Cou	ntry?
	th with	aiD	8601 Allentown I	Road			2074	4			USA	Α
Maryland 21215-0036	within 72 hours after death with the Maryland jiene. r then "neturel", or Items 23a or 28a-f show the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	12. Was Dec Armed F med Ty⊠Yes If Yes, G Year or I	orces? 2 ☐ No ive	WWII 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		k, White,	
5-0	72 h	etec	15. Deceder (Specify only highe	nt's Education est grade completed,	)	(Giv	edent's Usual Occup e kind of work done	during most of wo	orking	16b. Kind of Bu	siness/In	ndustry
121	within Bne. then	gmo	Elementary/Secondary (0-12)	College (	(1-4or 5+)		DO NOT use retired Printendent	3)		Construc	tion	
d 2	€ ¥ € £	Be Co	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle,			
/lan	d as a s	To B	Freddie L.	Ritter				Rosa	M. Cli	ne		
<b>far</b>	and		19a. Informant's Name/Relations				ing Address (Street					o Code)
	1 and 2 Heelth tem 27		Angela E. Ritter  20a. Method of Disposition	/ Wife		8601 A 20b. Place of Disp	11entown Ro	ad Ft. Was	hington, M	ryland 2		own State
Baltimore,	Page nent nent nury or		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)		cemetery, cre Maryland V	et. Ceneter	y 10/2	9/2007	Cheltenhan	ı, Mar	yland
Bal	permit. Departr Importe eny Inje		21. Signature Funeral Service	Licensee			22. Name and Addre				20745	
	Physician /Medical Examiner	er	23a. Parkf. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if the light factors in the conditions of the condit	a. Due to	each line.  OCS  (or as a co	a death. Do not en	SOPHA	ig, such as cardia	ac or respiratory ar	rest,	_/	Approximate Interval Between Onset and Death
oʻ	cate be executed physician and the burial-transit	Examiner	flairy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a co	onsequence of):					+	
68760,	tificate be ig physici es the bu	edical		d					22.11			
.O. Box	it the death certificate be executed by the attending physician and tached for use es the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 [ nant at tim	Fetal death 3	□Ectopic pregnancy □ Other (specify) _			23d. Date Mor		ery Day Year
ords, P	The law requires that the has been signed b page 2 should be deta	þ	Part II. Other significant condition  AUEALOSLE	ons contributing to d	death but n	ot resulting in the	underlying cause giv	en in ParkL	107			the cause of death?
Vital Records,		e Completed	25 West and referred to media		· · · · · ·				1 Tes	rmed? d 2XXNo 1	rior to co leath?	opsy findings available impletion of cause of
<u>=</u>	Physicien: this certific al director,	0 13	25. Was case referred to medica examiner? 1XXYes 2 □ No	Hospital:	Inpatient	2 ER/Outpatie	ent 3□ DOA Oth	00	eath (Check only on Home 5 12 Resid		ar (Sneci	60
n of		n: T	27. Manner of Death 1 XXIII 5 ☐ Pendi	28a. Date		28b, Time				now injury occurre		.,,
Sio	Attending r death. actor: After	catic	2 Accident invest	igation		, , , ,		Yes 2 □ No				
Division of	ttal or Attenors after death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ninger 289. Plac	e of Injury ding, etc. (S	- At home, farm, s Specify)	treet, factory, office		28f. Location (S City or Tow		or Run	al Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	Medicai	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To th Examiner: On the I and mar	e best of m basis of ex nner stated	amination and/or i	th occurred at the tir nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the curred at the time, o	cause(s) and mad date and place, a	nner as s and due t	stated. to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifie	er .			29c. Licens	1854	5	29d. Date signed	(Month,	Dey, Year) 24, 2007
2	HRAI		30. Name and address of person Philip M. Wiso	tsky, M.D.				#207, W	Waldorf.	MD 20602	)	-
	Sta Registr		31. Date filed (Month, Dey, Year OCT 2 9 200)	32.1	Registrar's		-					
				,					_			

(D43)

31. Date filed (Month, Day, Year)

OCT 3 1 2007 State Registrar

Ghousia Sultana, M.D. 12107 Heritage Park Circle Silver Spring, MD 20906 32. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#4c.PerPhys.PCC11-1-07cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2007 Elcio Simms October 23, 7:33 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery County Randolph Hills Nursing Home Wheaton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
March 22, 1924Washington, DC Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F Months 578-20-5804 83 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Directo Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Road 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify. 3 A Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrna L. Fawcett - Guardian 730 - 24th St., NW #15 Washington, DC 20037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Nov. 1, 2007 Landover, Stewart Funeral Home, Harmony Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4001 Benning Road, NE Washington, DC 20019 23a. Par 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis disease or condition resulting in death) Days /Medical Due to (or as a consequence of): Examiner Pneumonia Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sacral Decubitus The law requires that the death certificate be executed Months physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Hypertension 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 ☐Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

CR (2)

Anuradha Arun,
State
Registrar

Anuradha Arun,
31. Date filed (Month, Day, Year)
NOV 0 1 2007

M.D. 10301 Georgia

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Ave #209 Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#7. PerFHPGC11-1-07cr Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ovetta Spurlock /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georg urel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, State or Foreign Social Security Number **Funeral** 1 M 2 F 73 -4 577 48 1461 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County r 28a-f show notified at Columbia 1 Des 2 No Howard MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number rrai", or items 23a or i Examiner must be 21045 United States 5455 Wildwind Place 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black ò 3 ☐ Widowed 4 Divorced 'naturai". Completed 16b. Kind of Business/Industry item 27 Is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Clerk year 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental Hiant: If item 27 Is marked oth Be Estella Spencer Lorenzo Washington 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mabel Washington step-mother 206 Adams St., NE Washington DC 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 10/31/2007 Department of important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Washington, DC Mt. Olivet cemetery 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FUNGRAC Home Signature of Funeral DYLL ST. NE WASH DC 20017 3015 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death a. Part1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final disease or condition resulting in death) Aspiration Physician 30 mm - 1 hr /Medical Due to (or as a consequence of) Examiner Arrhythmia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Kespiratory Failure the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 🗖 No Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dealt To the Funeral Director completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number **ATTENDING** 00057216 2007 PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Baaku, M.D. 3450 Ft. Meade Rd, # 204 Laurel, MD

s

State 31. Date filed (Month, Day, Year, NOV 0 1 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** JOHN I. SHIRLEY, SR. OCT 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCES GEORGES LAUREL REGIONAL HOSPITAL LAUREL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 1 M 2 □ F **Funeral** Months 18/1920 WASH, DC 578 14 1544 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Pres 2 No Director SPRING MD. MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number USA. 20904 12325 NEW HAMPSHIRE AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 December 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK. Baltimore, Maryland 21215-0036 q 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL Elementary/Secondary (0-12) College (1-4or 5+) WAREHOUSE MAN GOVERNMENT. 12 VEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOTTIE YATES GEORGE SHIRLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRANYDWINE MD 20613 15 ON 11919 ELMWOOD DR JOHN I SHIRLEY, JR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition COLN 11/2/2007 BRENTWOOD ME 22, Name and Address of Facility INES FUNDRAL HOME 1 Deurial 2 □ Cremation 3 □ Removal from State FT. LINCOLN 4 □ Domation 5 □ Other (Specify) 21. Songure of Funeral Service Licensee, 3015 12th SINE WASH DE 2017 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** E. COLI Sequentially list conditions, it any, leading to finite distributed assets. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed ACUTE CHOLECYSTITI burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Winknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1□ Yes 2000 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Hospital: 1 Thepatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

C/C (3)

State Registrar ilod (Magth, Day, You) 32. Registrar's Sign

30. Name and address of person who compreted cause of death (Item 23a) (Type, Print),

D60936

DUSEN RD LAUREZ MD

			1 - For State Registrar		artment of Health and Nartificate of Death	fental Hygie	ZUU /	36519
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Marcella Scully  4a. Facility Name (If not institution, give street and	f number)	4b. City, Town, or Location of Death	Oct. 24,	2007 4c. County of Deat	8:35 A. M
	Examin	er			_		Freder	
	Funeral	7.	St. Vincent Care Cent 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Emmitsburg If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign
	Director		156-18-6135 1 M 2 X	F 79 Yrs.	Months Days Hours Min.	March 7	1928 N	ew Jersey
	pur *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Manyle febo	ō						1 √Yes 2 □ No
	128a-	Directo	MD Frederick  10e. Street and Number	Emmits	10f. Zip Code	10g.	. Citizen of What Co	ountry?
	23a o		335 South Seton Avenu	1e	21727		U.S.A.	
	r dea	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S. 13. d Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
9	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Iteme 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Fu	If Yes	es 2⊠No	1 ☐ Yes 2√ No Specify:		Specify:	
3	2 hours		15. Decedent's Education	16a. Dece	dent's Usual Occupation	16	b. Kind of Business	ite (Industry
25	hin 72	piet	(Specify only highest grade comple Elementary/Secondary (0-12) Colle	ge (1-4or 5+) (Give life.	kind of work done during most of work DO NOT use retired)	ring R	eligious	Community
7	ed wit	Completed	Col		cher			of Charity
ב	e d ia	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma		
Maryland 21215-0036	should be ind Mentail in marked o	္	Joseph C. Scully  19a. Informant's Name/Relations por Type 1 Pring	lam a mile a mar 19h Maili	Helen ng Address (Street and Number or Rui	Marie Cor		Zin Code)
<u>≅</u>	C		Sister Camilla Haran	-	South Seton Aven			
ā,	s 1 end 3 if Health item 27 other tr		20a. Method of Disposition	1	osition (Name of	Date 20	c. Location - City or	
Ë	Pages nent of int: if it		1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)		Crematory 10/2	9/2007	Winfiel	d, MD
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licensee	2:	2. Name and Address of Facility My			
<u> </u>	40 # # g		fusti K. Dun		10 W. Main Street			
			23a. Part I. Enter the disease, or complications to shook, or heart failure. List only one cause	on each line.	ter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between -Qnset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Vascul	1 Dement	la		145
	Examiner		11	e to (or as a consequence of):				0
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (ur as a consequence of).				
	acuted ind transi	Examin	that initiated events c.					
3/60,	icate be executed physicien and s the burlal-transit	cai Ex	resulting in death) Last Du	e to (or as a consequence of):				
289	The law requires that the death certificate be executed the has been signed by the attending physicien and tage 2 should be detached for use as the burial-transit	<u>-</u>	d					
XOR	eath certific attending pi	Physician/Me		outcome of pregnancy	Te		23d. Date of de	livery
	death ne atte	sicia	1 Yes 2 No		Ectopic pregnancy Other (specify)		Month	Day Year
J Ö	that the de led by the a detached	Phy	a C Oukrowu		and the same of the Boats	22a Did tahar	non una pontébuta t	o the cause of death?
Š,	signe d be d	Ď	Part II. Other significant conditions contributing	to death aut not resulting in the d	inderlying cause given in Part I.	1 ☐ Yes	~	robably 4 Unknown
ecords	w require been si should t	letec		The state of the s	O Vodivo,	24a. Was an	/~	utopsy findings available
ě	sician: The law certificate has l irector, page 2 s	Completed		V		autopsy performe	prior to death?	completion of cause of
Vital H		0	25. Was case referred to medical		26. Place of Dea	1 ☐ Yes 2 ☐	No 1 □ Yes	2 2 No
<u>&gt;</u>	Physician: r this certific ral director,	To B	examiner? 1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3□ DOA Other: 4 Nursing H	ome 5 Residence	ce 6 □Other (Spe	ocify)
	ding Pl h. After ti funera	ë.	1 Natural 5 Pending	Nate of Injury 28b. Time of Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
DIVISION	Attending in death.  ector: Altered by the fune	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location /Stree	et and Number or R	ural Route Number
<u>≥</u>	il or A efter Direct	Certification:		building, etc. (Specify)	reet, factory, office	City or Town,		oral riodo rombor,
	To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	aic	29a. Certifier Check only 2 Medical Examiner: On t	o the best of my knowledge, deat	h occurred at the time, date and place	and due to the cau	se(s) and manner a	s stated.
	the Hin 24 the Fi	ledical	one) and	manner stated.	vestigation, in my opinion, death occur			
		Σ	29b. Signature and title of certifie	2 //	29c. License number	290	J. Date signed (Mon	th, Day, Year)
	MIL			anous	010/0	)	10/10/	0 /
	1		30. Name and address of person who completed		eton Aue. Emm	Esbuea	MD DI	727
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		3	1 2 321	I from I
	Registr	ar	OCT 2 6 2007	Glown &	Soule			

		1	For State	State of Mar	yland / Depa <i>Cer</i>	irtment of He tificate of L			ene g. №2 ∩ ∩	7 00520
	16	Н	Registrar  1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		ar 3. Time of Death
	Physicia /Medic	al	Dorothy Jean Seaks						25 2007	3:59 P. <sup>M</sup>
)	Examin		4a. Facility Name (If not institution, give str Carroll Hospital C			4b. City, Town, or Westmins			4c. County of C	
	Funeral		5. Social Security Number 6. Sex	7. Age (	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9.	Birthplace (State or Foreign Country)
	Director		213-22-0370	м 2 <b>X</b> 1 F	83 Yrs.	Months Days	Hours Will.	8/18/19	10.4	laryland
	and w	-	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
	Maryli -f sho fied at	to	Maryland Baltimore	1	upperco					1 □ Yes 2 XNo
	th the or 28a e noti	Direc	10e. Street and Number		~	10f. Zip Code		1	Og. Citizen of Wha	
	ath wi	ral	5426 Arcadia Ave.	2 Was Doodant Ev	or in IIS 13 1	21155	Ispanic Origin? (Sp		United S	American Indian,
350	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall tyligned. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1    ↑ Never Married 2 Married  3    Widowed 4   Divorced	<ol> <li>Was Decedent Ev. Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 X No	Specify:	Rićan, etc.)	Specify:	White, etc. White
2-0036	72 hou natura dical E	Be Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	king	16b. Kind of Busin	ess/Industry
	within ane.	ndm	Elementary/Secondary (0-12)	College (1-4or 5+)		red Accou			Commerci	al Credit
D	i filed I Hygie other ent, th	e Co	17. Father's Name (First, Middle, Last)					e (First, Middle, N	Maiden Surname)	
yland	ould be Menta arked atic ev	To B	Vernon W. Seaks				Eva Mae			. 7.6.1
Mar	t2 shoth and hand 7 is material		19a. Informant's Name/Relationship (Typ Michael Franklin A)	COUSI	.Π Ι	ng Address (Street a				
<u>6</u>	s 1 and f Healt fem 2 other		20a. Method of Disposition		20h Place of Dispo				20c. Location - Cit	
E E	Pages nent of int: If i		1 ∯Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	St. Paul'	s Cemeter	cy   10/3			Maryland
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service License	18	M01490   M	lain stree	et Hampst	ead, Mar	yland 21	934 South 074
Ē			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the cause on each line	ne death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	PULMON	ARY HE	MORRH	HGE PO	OST B	10PSY	
	/Medical Examiner			Due to (or as a	consequence of):	LRF				
	4.7	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence or):	0-100				
	ecuted and -transil	Examin	Cause (Disease or injury that initiated events c.	DIA ST	Consequence of):	DYSFUN	vetion			
68760,	icate be executed physician and s the burial-transit	a E		CORON		RTERY	DISE	4SE		
687	tificate g phys as the	ledical						100		
. Box	death certifi e attending d for use as	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome p 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnanc	у		23d. Date of Month	
Ö.	0 0	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)				
<u>.</u>	that the		Part II. Other significant conditions con	tributing to death but	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
Records, P	The law requires that the deate has been signed by the bage 2 should be detached	ed by	MILD PULM	ONARY	HYPERT	ENSION		1 □ Y	′es 2 No 3	Probably 4 Denknown
eco	lan as	Completed						24a. Was a autop:	sv pri	ere autopsy findings available or to completion of cause of ath?
<u>=</u>	ysician: The iis certificate h director, page						00 Bl / D	1□ Yes	2 10 1	Yes 2□ No
<b>\(\frac{1}{2}\)</b>	siciar certifiirector	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	lospital:	it 2∏ER/Outpatie	ent 3 DOA Oth	nor:	ath <i>(Check only or</i> Home 5 ☐ Resid	lence 6 □Other	(Specify)
יסר	ding Phy 1. After this funeral o	n: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		of 28c. Inju	ry at rk?	28d. Describe h	now injury occurred	i
Sion	tendir leath. tor: Af the fur	catio	2 Accident investigation 3 Suicide 6 Could not be	00 - Place of lake	At home form o		]Yes 2 □ No	28f Location (S	Street and Number	or Rural Route Number,
Division or Vital	l or At after d Direct	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, s . <i>(Specify)</i>	ireer, raciory, critico		City or Tow	vn, State)	,
_	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Medical Co	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Exami	sician: To the best oner: On the basis of and manner state	examination and/or i	ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the within : Fo the xomple	Mec	29b. Signature and title of certifier			29c. Licen				(Month, Day, Year)
	MIL		Mr. 1 m			D	4282	7 (	o crosen	25,2007
	Wale		30. Name and address of person who co					n ( a	11	115440 01110
	C+	ate	MEHAEL LANSING 31. Date filed (Month, Day, Year)		CROSS (20)	DS DK.	SUITE	210 00	NGS MI	LLSMD 21117
	St Regist		OCT 2.6		we K	house .				

7 0	Q 5 /	0
)7-()	വാച	- 27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

onald Ray Spoor			ate of Marylar	nd / Depa	rtment of tificate of	Health ar Death	nd Menta	il Hygiene	Reg. No	. 2	2007	365
	Re	or State gistrar Decedent's Name (First, Midd	le Last)	Cer		Dodan		2 Date of De	eath			ne of Death 145 hrs
Physician Examine احتوا	"	Donald R	ay Spoonho	ur, Jr.				Month Novemb	er 3, 2	c. County o		
	48	. Facility Name (if not institution	on, give street and num	iber)	4	b. City, Town, o		Death		Carroll		
		Carroll Hospital Cent		7. Age (In yrs. la	ast hirthday)	If Under 1 Ye		24Hrs. 8. Date of	Birth (MN	//DD/YYYY	9. Birthplace Country)	e (State or Foreign
Funeral Director		Social Security Number	6. Sex	7. Age (III yis. ia 26	Yrs	Months Da		Min. May	13,	1981	Penns	ylvania
Director		sual Residence of Decedent	1 N 2 1								10d.	Inside City Limits
any	1	oa. State 10b. County		10c. City,	, Town or Locati	on	Keymaı	2			1 [	Yes 2 No
and show			rroll	l		10f. Zip Code			10g. C	itizen of Wh	nat Country?	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fitten 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be positified at once.	Director	De. Street and Number 1909 Crouse Mi	ll Road				217			_	JSA 	
ith the		1 Marital Status	12. Was Dec	edent Ever in U	J.S. 13. Wa	is Decedent of	Hispanic Origi han, Mexican,	n? ( Specify Yes or Puerto Rican, etc.)	No-		e - American l e, etc.	
eath w	Funeral	Never Married 2	1 103	2 X No	1	Yes 2				Specify:	white	ž
after d	Ď-		livorced If Yes, Give Yea or Dates:		Tito: Barada	eta Haual Occi	nation (Give k	and of work done	161	b. Kind of B	usiness/Indus	stry
hours a		15. Decedent's Education (S Elementary/Secondary (0-1			during n	nost of working	life. DO NOT	use retired)		Dogt	taurant	<del>-</del>
36 in 72 han "	Completed	11	2,			Cook			Un Maria			
d with	탉	17. Father's Name (First, Midd	le, Last)				18.Mother	s Name (First, Mide sephine (	Sie, Maid	ander	<sub>5)</sub> 3	
215 be file ntal H.	Be	Donald R. S	poonhour,	sr.	10b Mailir	ng Address (S	Street and Num	nber or Rural Route	Numbe	r, City or To	wn, State, Zip	Code)
21 hould nd Me is ma	유	19a. Informant's Name/Relation Josephine C.	onship (Type, Print) Click, mot	her	909	Crouse	Mill R	load, Key	nar,	MD Z	1757	
nd 2 sealth a	- }	on- Mathed of Disposition		20b	. Place of Dispo	osition (Name o	of cemetery,	Date			- City or Tow	
Ore	1	1 Burial 2 Crema		rom State	crematory or o Carroll	Crema	tory	11/5/20	07		field,	
it. Pagittment	}	4 Donation 5 Other 21. Signature of Funeral Serv	Specify: ice Licensee				droop of Eacilit	Myers- ore St, T	Durb	oraw town.	MD 21	787
Ba perm Depa Imp	ı	1 1	1	)ou		36 E.	Baltlik	pardiac or respirato	ry arrest	, shock, or h	neart	Approximate inten
Physician	7	23a. Pan I. Enter the disease failure. List only one ca	, or complications that use on each line.	caused the dea	ath. Do not ente	r the mode of a	ying, 3001 03 v	1:+: one	,			Between Onset ar Death
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Immediate Cause (Final dise	ase a. Narcot	a consequence	ine) into	oxication	with co	mplications				
amino		or condition resulting in deat	n) Due to (or as	a consequence							+	
	ler	Sequentially list conditions, if any, leading to immediate		a consequenc	e of):							
	Examine	cause. Enter Underlying Ca (Disease or injury that initiat events resulting in death) L	ed .	a consequenc	e of):							
ecuted and ransit		events resulting in death) E	d									
ਭਾੜ ਲ	dical	X UNPENDED	AMENDE	27,28a-f	, perME,g	874 <u>,</u> 12/6	6/07 TT			23d. Date	e of delivery	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician To the Funeral Director: After this certificate has been signed by the attending physician.	J.	IF FEMALE: 23b. Was decedent pregnant	in the 23c. If ye	s, outcome of p	regnancy 2	Fetal death	3 Ecto	pic pregnancy		Mont	_	ay Year
certifi	sician/Me	past 12 months?	4 Pre	egnant at time o		Other (Specif	ý)					
Box death the attred for ed for	Physi	1 Yes 2 No 9		known	not resulting in t	ne underlying o	ause given in					ne cause of death?
O. hat the ed by	by P	Part II. Other significant co	onditions contributing	g to death but i	lot resenting in a			1	Yes			ably 4 🗹 Unknow
S, P uires t uires t in sign Id be c	pa							248	a. Was a	L	prior to co	opsy findings avail ompletion of cause
ord aw req as bee 2 shou	le le							11	perfor Yes	med?	death? 1 ✔ Yes	s 2 N
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rasher death.  The process of the province of the provin	Completed					2	6.Place of Dea	ath (Check only one	9)			
n of Vital Fing Physician: After this certification	B.	examiner?	Hospital:	/ Inpatient	2 ER/Outpa		1			Residence		
of Vil ng Physia After this	1	27 Manner of Death		ate of Injury onth, Day, Year)	28b. Time	of Injury 2	8c. Injury at W		escribe h	now injury o	curred	
on on on on on one of the one of		1 Natural 5	Pending En	a 11/2/20	007 FNd 9	9:29 am	1 Yes 2		action (	Street and N	Jumber of Ru	ral Route Number,
ivision or Atteneather death Director:	ficatio	2 Accident 3 Suicide 6	Could not be 28e. I	Place of Injury -	At home, farm,	street, factory,	office building	g, etc.	Town, S	State)	al Cente	ral Route Number M er Westmine
Division To the Hospital or Attend within 24 hours after death	completely filled in by the func-	4 Homicide	determined (Specing Physician: To the	11000			time date and	Labora Am	the cour	o(e) and m	anner as state	ed.
To the Hospital Within 24 hours			ring Physician: To the	best of my kno sis of examina	owledge, death tion and/or inve	stigation, in my	opinion, death	h occurred at the tir	ne, date			
To the To the To the	complete	29b. Signature and title of	and main	ner stated.		290	. License num	ber		29d. Date	5 519.100 (1110	, = -,,
MIL	2	290. Signature and title of	11. 1	1/			O.C.M.E.	OCME		Novem	nber 4, 200	J/
Mac		30. Name and address of	person who completed	dause of death	(Item 23a)	»			. 0400	4		
		Theodore M. Kin	g, Jr., MD. Ass	sistant Medi	ical Examine	er 111 Pe	enn Street,	Baltimore, MD	2120	1		
	Sta	e 31. Date filed (Month, Day	(Year) 3	2. Registrar's S	11.49	Courte .	ø					
Reg	jistr	11011	0 7 20071	Decemen								
DUMU 17 Pay	1/200	1			ORIC	INAL						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month 2007 6:40A OCTOBER 27 **JAMES** STRIGGLES 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CLINTON PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) Months Min. 1 □ XM 2 □ F Days Hours 82 255-30-3135 22 1925 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WASHINGTON 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 20019 1009 46th STREET N.E. 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYes 2 No ARMY If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. BLACK Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) OWENS ROBERT L. STRIGGLES ANNA MAE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8900 BRANCH VIEW DRIVE FORT WASHINGTON, MD 20744 HOWARD/STEPSON **GEORGE** 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NAT'L CEME 11-2-2007 LAUREL, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensein J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on e on line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, many loading to minisorate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

DC

Director

Funeral

Completed by

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" any injury or other traumatic event.

Examiner Physician/Medical ģ Completed Be Certification: To

and led by the attending physician detached for use as the buna

To the Hospital within 24 hours a To the Funeral L

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed in by the funeral director, page 2 should be det after death. Director: After Medical

23b. Was decedent pregnant in the past 12 months? □Yes

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Matural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

/	<i>'</i>			26. Flace of Death (Check only one)							
ital: 1 Ir	npatient	2 ER/Outpati	ent 3□ DOA	Other:	ursing Home	5 Residence	6 □Other (Specify)				
8a. Date o	f Injury	28b. Time	of 28c	. Injury at	280	d. Describe how ini	urv occurred				

28a. Date of Injury (Month, Day Year)

and manner stated.

M 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hosp

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7700 OID Branch AVE #101 CliNtON, MD 28735 BERWAMD

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of L				77 26521
	Physicia	an_	1. Decedent's Name (First, Middle,	Last)				2. Date of Deat	eg. No. 20 ( th 25, 2007	ear
- <del>1</del>	/Medic	al	ROOSEVELT  4a. Facility Name (If not institution,	give street and number)	SKINNER	4b. City, Town, or		JCIUBER	4c. County of [	1014 1
) (27 ) irsid , (27 )	Examin	er	FORT WASHINGTO	_			WASHINGT	ON	PRINCE	GEORGE'S
	uneral rector		5. Social Security Number 433–76–9161	6. Sex 7. Age (In	n yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 24	4 <sup>Year)</sup> 1947 I	Birthplace (State or Foreign Country) OUTSTANA
Maryland	a-f show ifled at	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         PRINCE		FORT WASE					10d. Inside City Limits 1 Yes 2 □ No
h with the	23a or 28 st be no	Funeral Director	10e. Street and Number 3301 LUMAR DRIV	Έ		10f. Zip Code 20744		1	0g. Citizen of Wha	t Country?
III 4 14 15 15 1000  be filled within 72 hours after death with the Maryland ital Hygiene,	Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1    ↑ Never Married 2   ↑ Marrie  ↑ Divorced	12. Was Decedent Ever Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:	1	1 □ Yes 2 🛣 No			Black, \ Specify:	American Indian, White, etc. BLACK
1	than "natu ne Medical	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12) 11TH	s Education t grade completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of worki )	ng	16b. Kind of Busin PRIVATE	ess/Industry
be filed half	is marked other aumatic event, th	Be	17. Father's Name (First, Middle, L. JAMES SKINNER	.ast)			18. Mother's Name		,	
and 2 should I	7 is marke traumatic	To	19a. Informant's Name/Relationsh DOROTHY POTTS		19b. Mailin 3211	ng Address (Street a		al Route Number	r, City or Town, Sta TON, MARY	ate, Zip Code) LAND 20744
Pages 1 an	Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.	3 ☐Removal from State	20b. Place of Dispo- cemetery, cren	natory or other plac	TERY 11/3	I .	20c. Location - Cit	
partification permit. Pages Department of	Importan any injur once.		21. Signature of Funeral Service L		22	2. Name and Addres		B. JEN		ERAL HOME ND 20785
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that caused the only one cause on each line.						Approximate Interval Between Onset and Death
/M	sician edical		Immediate Cause (Final disease or condition resulting in death)		D HUMAN I					Onset and Death
Exa	miner	ē	Sequentially list conditions, if any, leading to immediate	bbue to (or as a co	onsequence of):					
oo/ou, ificate be executed	physician and s the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):					
orou, ate be ex	ysician he buria	edical E		d						
requires that the death certification	s been signed by the attending phe should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf p 1 □Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	
dS, F.	signed by d be detac	by	Part II. Other significant condition HEPATIC MASS	ns contributing to death but n	not resulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
he law	ate has beer oage 2 shou	Completed	CIRROSIS OF LI	VER				24a. Was a autop perfor 1□ Yes	sy prid rmęd? dea	ere autopsy findings available or to completion of cause of atth?  Yes 2 \sum No
VICAL ician:	certificate l rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	77.	ot 3D DOA Oth	26. Place of Deat			
VISION OF VITA Attending Physician:	fter this neral di	ion: To	1  Yes 2 No  27. Manner of Death  1 Natural 5  Pendin  2  Accident Investig	28a. Date of Injury (Month, Day Yo	2X ER/Outpatier  28b. Time o Injury	f 28c. Injur	4 LI Nursing Ho		lence 6 □Other now injury occurred	
DIVISION I or Attending	Director: in by the	Certification:	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 280 Place of injuny	- At home, farm, str (Specify)			28f. Location (S City or Tow		or Rural Route Number,
e Hospita	To the Funeral Director: A completely filled in by the fu	Medical Co	29a. Certifier 1   Check only 2   Medical one)	g Physician: To the best of n Examiner: On the basis of ex and manner stated	xamination and/or in	th occurred at the ti	me, date and place, opinion, death occur	and due to the orred at the time,	cause(s) and manr date and place, an	ner as stated. d due to the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier	19		29c. Licens	e number		29d. Date signed (	Month, Day, Year)
R	(4)		30. Name and address of person Bhavin Pate	1 M.D. 7501	Surratts	Road # 30	)7 Clinto	n,Marvla	and 20735	
	Sta Regist		31. Date filed (Month, Day, Year) OCT 3 1 2007	32. Registrar's	s Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#7perFH10/30/07, BMW, Moc Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Henry C. Scruggs October 27, 2007 6:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery if Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F Director 579-48-7365 07/16/1929 Tex<u>as</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 X Yes 2 □ No Anne Arundel Edgewater Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 3920 Rhode Harbor Rd. 21037 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Gyes 2 No 1961— If Yes, Give Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Scruggs Edith Brosius 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael C. Scruggs / Son Edgewater, MD 21037
Date 20c. Location - City or Town, State 3920 Rhode Harbor Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemet. 10/31/07 Silver Spring, MD 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Colon Cancer Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760 Physician/Medical as anding pure 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform certificate ha 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 QOther (Specify) Hospice Hospital: 1 Tes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending o. safter dea. seral Director: A' filled in by the investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check on one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0064615 10/27/2007

State Registrar 31. Date filed (Manth, Day, Year) 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Division or Vital Records, P.O. Box 68760 To the Hospital oswithin 24 hours aft

> State Registrar

29b. Signature and title of certifier

29c. License number

0056413

29d. Date signed (Month, Day, Year)

"COURT Hagerstown Mary kinel 21740

and manner stated.

38 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For State Registrar	State of	Marylan		artment of F ctificate of			giene 00	7 36527	
	1.0		Decedent's Name (First, Mid	dle, Last)					2. Date of Dea	ath	3. Time of Death	
	Physicia /Medic			James	Williar	n Scot	t		Month	Day Y	8:45 A M	
g -	Examin		4a. Facility Name (If not instituti	on, give street and numb	ber)		4b. City, Town, o	r Location of Death		4c. County of Death		
			302	Fairground Road				ince Frederic			Calvert	
	Funeral Director		5. Social Security Number 217-26-3448	6. Sex 7 1 X M 2 □ F	. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	8. Date of Birth (Month, Day, Year) 9. Birthplace Country) Oct 2, 1918 Mai		
	P _		Usual Residence of Decedent		10- 0:5	, Town or Lo						
	show	<u>.</u>	10a. State 10b. Coun	•	Toc. City	, TOWN OF LO		da e e Eus de d	_1.		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	he M 28a-f otifie	Director	MD	Calvert				rince Frederi		40 - Citimo - of 14th		
	h with t		10e. Street and Number 302 Fairground Roa	d			10f. Zip Code	20678		10g. Citizen of Wh	J.S.A.	
	ems ems	Funeral	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race -	American Indian, White, etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Member Hyglene. If Health and Member Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show then 17 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Ma 3 🗷 Widowed 4 ☐ Divorce	arried 1 Tes 2	≥ No		1 ☐ Yes 2 🗷 No	Specify:	, ,	Specify:		
2-0	72 ho natur lical	eted	15. Decede	ent's Education lest grade completed)		16a. Deced	dent's Usual Occup	ation during most of wor	rkina	16b. Kind of Busin	ness/Industry	
21	ithin 'e.	Completed	Elementary/Secondary (0-12)		4or 5+)	life. I	kind of work done OO NOT use retired		9	_		
N	filed withir Hygiene. Ither than	S	6 17. Father's Name (First, Middl	o Last)			ra	rmer	no /Eirot Middle	Maiden Surname)	arming	
	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middl	<i>s, casi)</i> Allison S	Scott			To. Mother S Nan		la (unknown)		
Ž	should ind Men marke	2	19a, Informant's Name/Relation			19h Mailir	ng Address (Street	and Number or Ri		er, City or Town, St		
Ma	and 2 s ealth an n 27 is her trau		Vonnell Dunscomb	, , , ,		Nava	1 Hospi 475, Bo	tal Yok x 1510	osuka FPO AP	96350	ato, air codo,	
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition		1 0	lace of Dispo	sition (Name of matory or other place	i	Date A1	20c. Location - Ci	ty or Town, State	
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any Injury or othe once.	-	1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other	(Specify)	tate	Metropoli	tan Crematory	10	/31/07	Alex	andria, VA	
Bal	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service			22		uneral Home	ad Prince F	rederick, MD	20678	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that car	used the death	n. Do not ent					Approximate Interval Between	
	Physician	ì	Immediate Cause (Final disease or condition	Càr	diac	Ax	rhythr	ma.			Onset and Death	
	/Medical		resulting in death)	Due to (o	r as a consequ		-		280 W	V.		
	Examiner	L	Sequentially list conditions,	b. Pth	<i>७१०</i> ८०		HC Can	chovas	cuker of	isease		
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	A Due to (o	r as a consequ	Jence of):						
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c	r as a consequ	uence of):						
68760,	icate be executed physician and the burial-transit	edical E		d								
68	ntifica ng ph as th	Nedi	IE EEMALE.									
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal int at time of de	Ideath 3[	Ectopic pregnanc Other <i>(specify)</i>	у		23d. Date Montl	,	
٦,	s that ned b e deta	by Pl	Part II. Other significant cond	tions contributing to dea	ath but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?	
ğ	w require been sig should b	ed b	multiple M	y occurdia	<u>l inf</u>	anchi	יתמ		1 🗆 '	Yes 2□No 3	Probably 4 □Unknown	
Records,	has been be 2 should	Completed	Chronic 0)	structive	Airl	nery	dispos	4	24a. Was	an 24b. We priormed?	ere autopsy findings available or to completion of cause of ath?	
a	iclan: The I certificate ha ector, page ;		meumonia						1□ Yes	2 <b>№</b> No 1L	Yes 2□No	
Vital	Physiclan: r this certifica ral director, p	o Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 🗆	EB/Outpeties	nt 3 DOA Oth	or.	ath (Check only o		(0 1/1)	
ō	ding Phy .r After this funeral d	$\vdash$	27. Manper of Death	28a. Date of	Injury	28b. Time o				dence 6 Other	· · · · · · · · · · · · · · · · · · ·	
ion	Attending I r death. ector: After by the funer	atior	1 ☑ Natural 5 ☐ Pend 2 ☐ Accident inves	ling (Month stigation	, Day Year)	Injury		rk? Yes 2 □ No				
Division	To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	: Zoe. Place C	of injury - At ho g, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,	
	Hospital 4 hours Funeral ely filled		(Check only 2 Medic	ring Physician: To the basel Examiner: On the base	sis of examina							
	o the vithin 2 o the omplei	Medical	one)  29b. Signature and title of certi	and manne	er stated.		29c. Licens	se number		29d. Date signed (	Month, Day, Year)	
	-> - ō		· ly	com. C.	du	ana	$\mathcal{D}$ .	5065	3.	10-25	- 2007	
dev	J 5		30. Name and address of person 5851 -	<b>A</b>	of death (Item		Print) GYI	AN.C.	SURF	MP 2	0751	
	Sta Registr		31. Date filed (Month, Day, Yea				Sperte					

			1 - For State Registrar	State o	f Marylar		artment of F		and Men		giene Reg. No	2007	365	28
	Physici		1. Decedent's Name (First, Middle Kathleen Faye		ki				2. I NO	Date of Dead Month	ath er 5	, 20Ŏ <sup>9</sup> 7	3. Time of 0	Death M
	/Medio Examir	_	4a. Facility Name (If not institution				4b. City, Town, o	or Location o				County of Death	1.000	
	LXdiiii	ici	Harford Memori	al Hospit	al		Havre	de Gra	ace			Harford		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2	24 Hrs. 8. [	Date of Birt	th y, <u>Y</u> ear)	Cou	place (State or	_
	Director		217–22–4855 Usual Residence of Decedent	ILIM ZLALF	82	Yrs.			8,	/8/19	25	Nort	h Caro	lina
	land w		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation						10d. Inside City	y Limits
	the Marylar 28a-f ehow	ţō	MD Hari	ord		Aberde	en						1 ☐ Yes	2 <b>⊠</b> No
	ith the	lrec	10e. Street and Number				10f. Zip Code				10g. Cit	izen of What Cou	ntry?	
05	23a c	ai	121 Valley Roa	ad			21	001				U.S.A.		
25	rs atter death with the Maryland ", or Iteme 23a or 28a-f ehow kaminar must be notified at	by Funeral Director	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Orig an, Mexican	gin? (Specify 1, Puerto Rica	Yes or No in, etc.)	-	<ol> <li>Race - Ameri Black, White</li> </ol>		
80 80 100 80	rs atte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Gir	2 ☑ No ve		1 □ Yes 2½ No	Specify:				Specify: Whi	te	
— Ş	72 hours "naturel", idical Exa		15. Deceden	t's Education		16a. Dece	dent's Usual Occup	oation			16b. K	ind of Business/Ir		
215	hin 73	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (	1-4or 5+)	(Give	kind of work done DO NOT use retire	<i>during</i> most d)	t of working					
213	ed wit	Completed	10		.,,,	Bea	utician	T				r dresse	er	
8 Y	tal Hyd off	Be	17. Father's Name (First, Middle,						er's Name (Fir			Surname)		
S E	should Ind Meni	٦ د	J. Curtis Ga			10h Maili	ng Address (Street		nanda E			Town Chata 7	- Codel	
000000000000000000000000000000000000	s 1 end 2 should be filed within 72 hour f Heelth and Mental Hygiene. Item 27 is marked other then "naturel other traumatic event, the Mcdical E.		Judy K. Bolen		r)		Valley R					aryland	21001	
/	H H H		20a. Method of Disposition	(Daugiice			osition (Name of matory or other pla		Date	or acc.		ocation - City or T		
i, Ka	permit. Pages Department of Important: If It any injury or o	1	1 ☐ Burial 2XI Cremation 4 ☐ Donation 5 ☐ Other (S		State		erris & C		11/8/07	7	Wes	t Cheste	er, PA	
alt:	partm porta		21. Signature of Funeral Service		1 -1	2:	2. Name and Addre	ss of Facility	ty				•	
~ <u>m</u>	g 9 E 9		KUSTENT	T. Wish	espe	LA	arring-C berdeen,	argo Maryl	unera. Land	21001	=339	9 <sup>A</sup> •		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	caused the dea	th. Do not en	ter the mode of dyin	ng, such as	cardiac or res	spiratory a	rrest,		Approximate Interval Betw	/een
	Physician		Immediate Cause (Final disease or condition	_a. A	SPIR	ATION	INE	DMO	NIA	•			Onset and D	eatn
-	/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):	ON ROLL	1 0		0 CT	7~^	)		
せ		-e	Sequentially list conditions,	b. Due to	or as a consec	uence of):	CARDIA!	~ (/	NFA	17011				
0 %	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A	CUTE	CET	REBRAL	- cr	YFAA	PCT/	ON	)		
$\sim p$	be executed icien and burial-transit	Exa	that initiated events resulting in death) Last		(or as a consec									
) 8760,	ate be ex hysicien he buria	lcai		L d										
89			IF FEMALE:											
box 6	eath certific attending pl	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months?		ointh 2 ☐ Feta	al death 3	Ectopic pregnanc	у				23d. Date of delive Month	,	ear
0.	it the de by the a tached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregr 9☐Unkn	nant at time of o	death 5L	Other (specify) _						,	
- d.	es that th gned by be detac	/Ph	Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	inderlying cause giv	en in Part I.		23e. Did t	obacco i	use contribute to	the cause of de	ath?
rds /	quires n sign uld be	q p	URINARY	TWAC	TIN	PEC	TION			1 🗆 🗅	Yes 2	Mo 3 Pro	bably 4 □U	nknown
	aw requir	olete								24a. Was		24b. Were aut	opsy findings a	ıvaılable
æ	The lav te has vage 2	mo								autor perfo 1 Yes	osy ormed? 2D No	death?	ompletion of ca 2□ No	use of
<u> </u>	ysician: The is certiticate hadirector, page	BeC	25. Was case referred to medica examiner?					26. Place	of Death (Cf					
>	Physic this ce al dire	၉	1 ☐ Yes 2 ☐ No			ER/Outpatie	IL SU DOA		ırsing Home	5 ☐ Resid	dence	6 □Other (Spec	fy)	
S C	ding P h. Atter t funera	ion:	27. Manner of Death 1 Natural 5 ☐ Pendir	9	of Injury th, Day Year)	28b. Time o Injury	Wo			Describe I	how inju	ry occurred		
// Division of Vital Reco		icat	2 Accident investigned investigned a Suicide 6 Could	not be	of Injury - At h	nome farm et	M 1	Yes 2 1		Location /	Street ar	nd Number or Rui	al Route Numb	79 <i>r</i>
D.	atter atter Dire	Certification:	4 ☐ Homicide determ	buildi	ing, etc. (Speci	ify)	reer, ractory, onice			City or To			21 / 10010 / 10110	,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely tilled in by the	Medical C	29a. Certifier (Check only one)  Certifyir 2 Medical	ng Physician: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred at the ti	me, date and opinion, deal	d place, and th occurred a	due to the	cause(s date and	and manner as d place, and due	stated. to the cause(s)	
	To th withir To th	ž	29b. Signature and title of certifie	1	7	0	29c. Licens	se number	3.4		29d. Da	te signed (Month	Dey, Year)	~ =
			Hadrw 1	bwale	swy	C'M,	DDE	YOY	16	1	NOV	BMBER	5,20	0+
	H		30. Name and address of person ANDREN NO	who completed caus	se of death (Ite	m 23a) (Type,	Print) Z Z	ULFI	DKD A	14	30	ZAIR.	MD2	1016
	Sta	te	31. Date filed (Month, Day, Year)	2. P	tegistrar's Sign		A 8	- / 0				• 4		
	Registr		NOV 1 4	2007 Lile	130 13	A STATE OF THE PARTY OF THE PAR	TO SECOND							

			Plea	se Type or State	Print in E	id / Depa	artment	of H	lealth :	and N	lental Hy	giene			
4	Physicia /Medic		1. Decedent's Name (First, Middle Hazel Arlene Ta			Cei	Certificate of Death					Reg. No. 4 eath 23/200		3.3 moorbeal 12:00p	29 mM
	Examin		4a. Facility Name (If not institution 2460 Bell Branc		umber)			Town, or mbr	Location ills	of Death			ounty of Dea		
er ec	Funeral Director		5. Social Security Number 332–26–0735	6. Sex 1 ☐ M <b>X</b> XF	7. Age (In yrs. <b>7</b> 5		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6/12/	th 1932	9. Bir <i>C</i>	thplace (State or For ountry) IL	reign
	iryland ihow f at	L	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel	10c. Cit	y, Town or Lo								10d. Inside City Lin	_
	vith the Ma or 28a-f be notified	Directo	10e. Street and Number 2460 Bell Brand				10f. Zip		21054			10g. Citize	en of What C		
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flee Z1 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 □ Divorced	12. Was De Armed I ried 1 ☐ Yes	2 X No Bive		Was Deced If Yes, spec 1 ☐ Yes	lent of H cify Cuba		rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)			erican Indian, te, etc. White	
20-61213	within 72 hou iene. • than "natura the Medical E	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12		() (1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us omemak	rk done d se retired	durina mo	st of work	king	16b. Kin	of Business	·	
alla i	ild be filed lental Hyg ked other ic event, i	To Be C	17. Father's Name (First, Middle, Noble Hankins	Last)			-				e (First, Middle Snyder	, Maiden S	Gurname)		
INIAI y	and 2 shou alth and N 27 Is mai er traumat		19a. Informant's Name/Relations Diane Middleton		ter						ton, MI			Zip Code)	
i i i i i i i	it. Pages 1 a artment of He ortant: If item injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (3	Specify)	n State	Place of Dispo cemetery, cre tro Cre	emator	У		10/2	25/2007	Balt:	imore,	r Town, State  MD  me, P.A.	
ם ס	permi Depa Impo any ir		Vatt 9	W	2		l2 Ric	lge1	y Ave	. A	nnapoli	is, M			
	Physician /Medical Examiner		23a. Part1. Enter the 1s ase, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	meta o (or as a consec	stati						arrest,		Interval Between Onset and Deat	th ,
	\$	iner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	b. Due t	o (or as a consec	quence of):									
,0070	cate be executed ohysician and the burial-transit	dical Examiner	that initiated events ' resulting in death) Last	c	o (or as a consec	quence of):									
O. DOY 0	To the Hospital or Attending Physician: The law requires that the death certificate be ew within 24 hours filer death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Liv	outcome pf pregne birth 2 Fet regnant at time of known	al death 3	□Ectopic pi □ Other (sp		у			2	3d. Date of d Month	elivery Day Year	r
Olds, T.	uires that the signed by the detaction	by	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	underlying o	ause giv	en in Part	: I.			. /	to the cause of death	
וויייייי	The law req ate has beer page 2 shou	Completed										opsy formed?	prior to death?	autopsy findings avai o completion of cause es 2 \( \square\) No	ilable e of
2	siclan: certific irector,	Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	]ER/Outpatie	not 3 🗆 DO	Oth	2011		th (Check only		Othor (St	nacify)	
5	ding Phy h. After this funeral di	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	28a. Da	te of Injury onth, Day Year)	28b. Time of Injury		28c. Injui Wor			28d. Describe			ecny)	
	s fter dear al Director	Certification:	3 Suicide 6 Could	minad   200. Fit	ce of injury - At hilding, etc. (Spec		treet, factor	y, office			28f. Location City or To	(Street and own, State)	i Number or	Rural Route Number	;
	e Hospit 24 hour e Funera letely fills	Medical (	29a. Certifier 1 Certify (Check only one)	ing Physician: To Il Examiner: On the and m	the best of my kn basis of examin anner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the ti	ime, date opinion, d	and place eath occu	e, and due to thurred at the time	e cause(s) e, date and	and manner place, and d	as stated. ue to the cause(s)	
	To th within To th	Me	29b. Signature and title of certifi	ten	1	-	29	c. Licens	se number	70		29d. Date	e signed (Mo OC+ 2	nth, Day, Year) 23, 200	7
	por	V	30. Name and address of Arson  Dan Laher	n who completed ca	ause of death (Ite	m 23a) (Type	Print)	ite	1 1	650	or lean-	154	Balt,	nth, Day, Year) 23, 200 MD 212	231
ì	Sta Regist	ate	31. Date filed (Month, Day, Year	2007	Registrar's Sign	nature	، بور								

Amended Item 10b per F.D. 10/29/2007 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar		aryland / Depa <i>Cel</i>	artment of H		Re	g. No 200	
Physic /Med		Decedent's Name (First, Middle, Las Sharon Lo	raine Tho	mpson			2. Date of Death Month October	Day Ye	3. Time of Death  5:25 p M
Exam		4a. Facility Name (If not institution, give Carroll Hospice I				Location of Death		4c. County of Car	Peath Troll
Funera Directo	_	178-34-2496	9x 7. Agr □ M 2 <b>%</b> F	e (In yrs. last birthday) 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 16,	<sup>y</sup> ear) 9. 1943 P	Birthplace (State or Foreign Country) ennsylvania
Maryland -f ahow	tor	Usual Residence of Decedent  10a. State  Maryland  10b Montgon  Memtgon	ery	10c. City, Town or Lo		thersburg	9		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
ath with the Marylan 23a or 28a-f show	i Director	10e. Street and Number 404 Girard Street	t, Apt. 30	3	10f. Zip Code	20877	10	og. Citizen of What USA	-
items	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 MiDivorced	12, Was Decedent   Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	10	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp.n., Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		American Indian, White, etc. White
within ane.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most of world)	king	Stock E	ess/Industry Brokerage
be file	To Be Co	17. Father's Name (First, Middle, Last) Frank Thompson			<u>-</u>	18. Mother's Nam	ne (First, Middle, M ret Broez	Maiden Sumame)	
Mary nd 2 shou alth and N 27 is mar		19a. Informant's Name/Relationship (1) Michelle A. Carr,		19b. Mailir 4820	ng Address <i>(Street a</i> Old Harri	and Number or Ru. .sburg Rd	ral Route Number, Lot 121	City or Town, Stat , Gettysk	ourg, PA
Page ento		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			osition (Name of matory or other place Crematory		Date 2 0/2007	20c. Location - City Winfiel	
permit. Pa Department importent any injury once.		21. Signature of Funeral Service Licen	Dompar	9	2. Name and Addres	ss of Facility My Street,	ers—Durb Westmins	oraw Fune ter, MD 2	eral Home 21157
ficate be executed // Medical Examinet Examinet is the burial-transit		Shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flag, wading to minadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as.	a consequence of):	TIC ()	renor	5 4	AN CON	Interval Batween Onsel and Death
death certifications of for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ □ 0 9 □ Unknow	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
law requires thet the as been signed by the 2 should be detached.	þ	Part II. Other significent conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob		te to the cause of death?  Probably 4 Unknown
The The ate h	Completed						24a. Was ar autopsy perform 1 Yes 2	prior	
S 00 00	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Mann of reath   Accident investigation	Hospital: 1 Inpatie	v 28b. Time of	28c. Injury Work	ar: 4 ☐ Nursing H	th (Check only one orne 5 Reside 28d. Describe ho	nce 6 lether (S	specify) Hispace
tel or Attending rs after death. el Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, str c. (Specify)	eet, factory, office		28I. Location (Str City or Town		r Rural Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director; After th completely filled in by the funeral	Medical	(Check only 2 Medica Exemone)	sicien: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or in- ted.	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occur	red at the time, da	ite and place, and	due to the cause(s)
11/4	,	29b. Signature and title of certifler			29c. 1 con ce	G30	3) 29	$\frac{10}{2}$	onth, Day, Year)
1075		YOUSUFNOALLA	completed cause of de	eath (Item 23a) (Type,	Print) Her Stro	ect we	STHIW:	er M	21157
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	1			·	

10:55 a M

9. Birthplace (State or Foreign

10d. Inside City Limits 1 ☐Yes 2 No

Approximate Interval Between Onset and Death

Month

Day

Year

Maryland

10:554

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

OCT 25

2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Year October 26, 200 8:00 PM GREYDON SWIFT TOLSON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN Birthplace (State or Foreign Country) PA 8. Date of Birth (Month, Day, Year) JULY 31 1 If Under 1 Year If Under 24 Months Days Hours 7. Age (In yrs. last birthday) 5. Social Security Number Days 1**2** M 2□F 1922 JULY 85 216-16-0115 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No MONTGOMERY DICKERSON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20842 USA 21521 PEACH TREE RD. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE WWII 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) FORESTRY FORESTER / ARBORIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NAOMI WATSON PAUL ERDMAN TOLSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4006 MAGNOLIA AVE., PETALUMA, CA 94952 BRIAN TOLSON / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State FREDERICK, MD STAUFFER CREMATORY 10/29/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HILTON FUNERAL 21. Signature of Funeral Service Licensee P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) umorare Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2□No 1∐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Hospital or Attending Physician:

24 hours a Funeral I

within 24 ho

To the Fune

completely f

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

within 72 hours after death

ges 1 and 2 should be filed within it of Health and Mental Hygiene. If Item 27 is marked other than "

permit. Pages 1
Department of H
Important: If Itel
any injury or ott

Maryland 21215-0036

Baltimore,

Director

Funeral

ģ

Completed

Be

Examine attending physician and for use as the burial-tran Physician/Medical been signed by the should be detached Completed by certificate has be irector, page 2 s filled in by the funeral director, Be Certification: To After 1 after death Director:

3 ☐ Suicide

29a. Certifier

4 Homicide

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient 1 Yes 2 No 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury Natural 5 Pending 

investigation 6 Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier 470

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ROBERT GUEDENET, MD 21 WYAND DR., KEEDYSVILLE. 21786 32. Registra 's Signature

State Registrar

Medical

State Registrar

31. Date filed (Month, Day, Year)

NOV 0 2 2007

Dr Igbal



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown Maryland 21742

77	08326	

Do

20	0	7	0	m	N-m	0
20	U	1	3	h	h	3

-08326		Please Typ	e or Pri	nt in Bla	ck Inde	elible li	nk. En:	sure	All Co	pies	Are Leg	jible.	20	07 000
nna Elizabeth	Tur	ner St	ate of Ma	ryland /	Departr	ment of	Health	and	Menta	al Hyg	giene		21	07 365
		1- For State Registrar			Certifi	icate of	Death				Re	g. No.		
Physicia		Decedent's Name (First, Midd	le,Last)							2.	Date of Deat Month	n Day	Year	3. Time of Death
. Exami	ner	Donna El	izabeth	Turn	er						October 26	3, 2007	real	0842 hrs
		4a. Facility Name (if not institution	on, give street a	ind number)			4b. City, To		ocation of	Death			ounty of Deat	th
		55 South Potomac St	reet			1	Hagers	town				Was	shington	
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. last l	birthday)	If Under		If Under	_	8. Date of Birt	h(MM/DD/	(YYYY) g. Bi Forei	rthplace (State or
Director		216-54-7823	1 M 2	(XF	58	Yrs	Months	Days	Hours	Min.	Oct.15, 1949 Counteryland			
	- 1	Usual Residence of Decedent					<u> </u>							
any		10a. State 10b. County		1	0c. City, To	wn or Locat	ion							10d. Inside City Limits
nd Show	_	Maryland Was	hingtor	, İ		Н	agers	town						1 X Yes 2 No
aryla 8a-f	둟	10e. Street and Number	<u>.</u>	·			10f. Zip C				10	g. Citizen	of What Co	untry?
he M	Funeral Director	55 South Pot	omac St	reet				217	40				USA	
with 1 is 23s	<u>a</u>	11, Marital Status		as Decedent E	ver in U.S.	13. Wa	s Decedent			n? (Spec	cify Yes or No-	14.	. Race - Ame	erican Indian, Black,
eath item	ne	1 Never Married 2 M	allieu	ned Forces? Yes 2 🛭	No	If Y	es, specify	Cuban, I	Mexican, f	Puerto R	ican, etc.)		White, etc.	
fter d ", or er m		3 Widowed 4 X Div	vorced If Yes, G	ive Yeer	NO	1	Yes 2	No	specify:			Sp	ecify: W	/hite
urs a fural	d by	15. Decedent's Education (Spe	or Dates ecify only highe		leted) 16		nt's Usual O					16b. Kind	d of Business	s/Industry
72 ho	Completed	Elementary/Secondary (0-12)	Coll	ege (1-4 or 5+	+)	during m	ost of worki	ing life. D	OO NOT u	ise retire	d)			
336 thin ne.	ը	12	ŀ				Cas	shie	r				Groc	ery
5-0 ed wi lygien of her	Ö	17. Father's Name (First, Middle	, Last)	-				18	3.Mother's	Name (F	First, Middle, I	Maiden Su	rname)	
21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	Joseph Lyn	Staley						Loli	ita	M. Re	eed		
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itan: If Titen 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	ို	19a. Informant's Name/Relations	ship (Type, Prir	nt)		19b. Mailin	g Address	(Street	and Numb	er or Ru	ral Route Nun	nber, City o	or Town, Sta	te, Zip Code)
MD 1d 2 sho alth and m 27 is		Allan D. Turn	er - Sc	n							lliamsp			
Titen		20a. Method of Disposition  1 Bunial 2 XXCrematio	- 2 🗔 Dam	accel from Chat		ce of Dispormatory or of	sition (Name	e of ceme	etery,		Date	20c. Loc	ation - City o	or Town, State
no pages ant of other		4 Donation 5 Other		ovai irom Stat				mato	ry N	Nov.	1,2007	Smi	thsbur	g, Maryland
		2). Signature of Funeral 87 vice	Licens e								e, P.A.			
Balt permit Depart Impor injury		/ Land (	A-			42	5 S. (	Cono	coche	eaque	e St. V	Villi	amspor	+, MD 21795
ysician		23a. Part I. Enter the disease, o failure. List only one cause	r complications	that caused t	he death. Do	o not enter	the mode of	dying, s	uch as ca	rdiac or i	respiratory arr	est, shock	, or heart	Approximate Interval Between Onset and
⊸/Medical		Immediate Cause (Final disease	D											Death
Examiner		or condition resulting in death)		or as a consec	quence of):									
		Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause		or as a consec	quence of):									
	am	(Disease or injury that initiated events resulting in death) Last	C	or as a consec	quence of):			-						
P.O. Box 68760, that the death certificate be executed red by the attending physician and detached for use as the burial - transit		events resulting in death) Last	d.											
executed an and al - transi	ical	UNPENDED	AMEN	IDED	-									
68760, certificate be nding physici	Physician/Medi	IF FEMALE:		If yes, outcom-	e of pregnar	ncv						23d. [	Date of delive	ery
197 Hiffice Ing pl as th	Į,	23b. Was decedent pregnant in to past 12 months?		Live birth	· p · - g · · · ·		etal death	3	Ectopic	pregnan	су	м	lonth	Day Year
Box 68760, e death certificate be the attending physic ed for use as the bur	ici	1 Yes 2 No 9 ✔ Ur	4	Pregnant at t	ime of death	5 0	ther (Speci	ify)				- 1		
B G degraph of the second of t	h		3 _	Unknown							00 - Did			1- 1b
P.O.	by F	Part II. Other significant condi	tions contrib	uting to death	but not resu	ilting in the	underlying	cause gi	ven in Par	rt I.				to the cause of death?
es es	y pe													
cords, law require has been see 2 should be	Jet										24a. Was autoj	osy	prior t	autopsy findings available o completion of cause of
Recc The lav	Completed											rmed?	death'	
tal Rection: The		25. Was case referred to medic	al		-		2	6.Place	of Death (	Check or	L			
Vita hysicia this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital:	1 Inpatier	nt 2 EF	R/Outpatien	t 3 DC	OA C	Other:	Nursing	Home 5	Residenc	ce 6 🗸 Otl	her: Scene
Division of Vital Records, rs after describing Physician: The law requir rs after death. After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should	<u>-</u>	27. Manner of Death	288	. Date of Injur	у 2	8b. Time of	Injury 2	8c. Injury	y at Work?		28d. Describe			
on on the fur	Certification: T		lullig	(Month, Day Ye ct 26, 2007	0	815 hrs		1 Y	es 2 🗸	No S	Subject to	und s	ubmerge	d in bathtub
ivision or Attencather death Director:	ica		estigation 28	e. Place of Inju	ury - At hom	e, farm, stre	et, factory,	office bu	uilding, etc	;. ;			Number or	Rural Route Number, City
Division spital or Attend hours after death neral Director:	erti	Daloido	uld not be ermined (S	pecify) Mul	ti-Family	Apt.				5	or Town, 5 5 South Pot	State) omac Str	reet, Hager	stown, MD
in i		29a. Certifier 1 Certifying F	Physician: To	the best of my	knowledge,	death occu	irred at the	time, dat	te and plac	ce, and o	due to the cau	se(s) and	manner as s	tated.
To the Howithin 24 h To the Fun	Medical	(Check only one) 2 ✓ Medical Ex	aminer: On the	basis of exam	nination and	or investiga	ation, in my	opinion,	death occ	curred at	the time, date	and place	e, and due to	the cause(s)
To wit	Mec	29b4 Signature and title of certif	and ma	anner stated.					number					Month, Day, Year)
00		More in 1	601/1	. 1 0				O.C.N	Л.E.			Octob	per 27, 20	007
VU		30. Name and address of perso	ne y	ry V	ath (Item 22	3a)								
X V		Margarita Korell MD					Penn Stre	eet. Ba	ltimore	. MD 2	1201			

ORIGINAL

37 Registrar's Signature

Mende

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2007 NOV. /Medical JAMES LEO THOMPSON 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**XM 2 □ F MARYLAND JAN.28,1930 Director 220-32-5659 r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director PRINCE GEORGE'S BRANDYWINE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or U.S.A. 20613 4240 KAYAK DRIVE Funeral 14. Race - American Indian, Black, White, etc. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items : any Injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: AMERICAN 1 ☐ Yes 2 ☐ No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced INDIAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GROCERY CHAIN MAINTENANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ROSIE ELLA PROCTOR JOHN ROBERT THOMPSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4240 KAYAK DR. BRANDYWINE, MARYLAND 20613 MARY BETTY THOMPSON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.PETER'S CEM. 11/9/2007 WALDORF, MD 21. S. natur of Funeral Service Licer 22. Name and Address of Facility RAYMOND FUNERAL SERVICE P.A. 5635 WASHINGTON AVE. LAPLATA, MD 20646 M00641 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VZGCYLZK Acute Ceve bra /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street and Number or Rural Route Number, City or Town, State)

attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760 signed by the a To the Hospital or Attending Physician: after death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

altimore,

Certification: To 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical

l 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hern Ave SE, DC 20032 1328 aime 2 Registrar's Signature 1. Date filed (Month, Day, Year)

Nov- 5- 2007

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar amend #5 Per FH G877 3/21/08Centificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DOROTHY AUGUSTA NOV. 6,2007 4:12P ULLMAN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER PLATA CHARLES LAIf Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 215-84-6383 6. Sex **Funeral** Hours Min. 1 □ M 2√2 F Months Days 76 MARYLAND Director NOV.16,1930 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at CHARLES CHARLOTTE HALL 1 Yes 2 No MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15185 OAKS ROAD 20622 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: WHITE 2 3 Widowed 4 □ Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. BUNKER HILL TAVERN Elementary/Secondary (0-12) College (1-4or 5+) PROPREETOR AND STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be if Health and Menta item 27 is marked THOMAS AGUSTUS SIMPSON ALICE CATHERINE LUCAS ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA SIMPSON-SISTER-IN-LAW 2560 DAVIS RD. WALDORF, MD. 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot MSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST.JOSEPH'S CEMETERY 11-10-07 POMFRET, MD. 22. Name and Address of Facility 21. Signature of Juneral Service Lice M00479 RAYMOND FUNERAL SERVICE, P.A. PLATA MD ne mode of dying, such as c MD . 20646 such as cardiac or respiratory arrest, LA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Do not ente d the death. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequent of): Examiner Mei ewelle if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 9 8 1 Yes 2No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 24 No ၉ 1 Inpatient 2 KER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) adLine Ctr #302, waldorf. MD ZOLOZ leted cause of death (Item 23a) (Type, Print) 12070 ochherwood

State Regi<u>strar</u> 31. Date filed (Mg

4 2007

DHMH 17 Rev 1/2001

2. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician October 26,2007 4:15am<sup>M</sup> Pauline Ward /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Genesis Nursing Home La Plata 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Months Yrs Md. 220-16-9012 94 19,1913 Mar. Director Usual Residence of Decedent death with the Maryland 10c. City Town or Location 10d. Inside City Limits 10a. State 10b County r than "natural", or items 23a or 28a-f show the Mudical Examinar transf be notified at WYes 2 No Director Charles La Plata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number One Magnolia Drive 20646 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: δ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Babysitter 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 le marked oth Mamie Marshall Frank Warren 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 of Department of Health ar Important: If item 27 le any injury or other trauonce. 13 Prospect Ave., Indian Head, Md. 20640 Richard Ward/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Welcome, Md. Zion Baptist Cem. 11/3/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bluford Funeral Service 21. Signature of Funeral Service Licensee 2670 Crain Highway, Waldorf, Md 20601 Myle NBlu 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each; line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physicien a I for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 menths? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed by t d be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 2 No 3 Probably 4 Unknown 1 ☐ Yes been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? 1 Yes 2 ☐ No 2 No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) : After this ce tuneral dire 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 THomicide within 24 hours after To the Funeral Dire Le Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 225 e of death (Item 23a) (Type, Print) 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Oct. Wright 8:45A /Medical Margaret 26 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Hospice-Dove House <u>Carroll</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2√2 F 95 Director 216-09-8464 1912 12. MD Sept. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show other traumatic event, the Medical Examiner must be notified 1 □ Yes 🏋No Sykesville Director MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 United States 1442 Buckhorn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ ¥Vidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker of Health and Mental Hygin Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esworthy Granville Dayhoff Blanche ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21771 Sharon Franklin/daughter Road Mt. Airy, 6111 Cabbage Spring 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I-Important: if ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Grove Cem. Oct. 30, 2007 Mt. Airy, MD Locust nature of Funeral Service License 22. Name and Address of Facilit Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Part1. Inter the dise se, or complications the shock, or heart failure. List only one cause used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final Physician lisease or condition /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 -NO Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Pother (Specify) To 1 ∐ Yes 2 [Z]-Mo 27. Manner of Death 28a. Date of Injury 28h Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural s after dea. al Director: Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

5 State

WJL

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 29

and address of person who completed cause of death (Item 23a) (Type, Print)

2007

SULTE

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

29c. License number

20806

29d. Date signed (Month, Day, Year) 2007

26

Physician /Medical Examiner The law requires that the death certificate be executed

Department of I Important: If its any injury or o once,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

if Health and Mental Hygiene. Item 23a or item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be not

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

Funeral

Completed by

Be

၉

death with the Maryland

burial-trar physician a the burialattending p for use as been signed by the should be detached certificate has birector, page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t

Division or Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not enter the one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	a	can sate	morbin	-	Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):	when to	inne		
lical Exam	Cause (Disease of Injury that initiated events resulting in death) Last	c	tehl blu	Melih:		
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy er (specify)		23d. Date of deliver Month	y Day Year
ed by Ph	Part II. Other significant conditions	contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobad	cco use contribute to the	e cause of death? ably 4 ∐Unknown
Somplet		high having		24a. Was an autopsy performa 1  Yes 2.5	prior to com	sy findings available apletion of cause of 2 No
Be (	25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)		
P	1 ☐ Yes 2 A No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Ho	ome 5 Residence	ce 6 □Other (Specify	)
ation: 1	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how	injury occurred	
Sertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, the building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
Medical Certification;		nysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.				
Me	29b. Signature and fitte of certifier		29c. License number	29d	. Date signed (Month, L	Day, Year)
	▶ \( \lambda \) \( \lambda \)	10(29/07				

State

Registrar

Charlotte Hall Rd. Charlotte Hall, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29449

Ahmad Heshmat.M.D.

OCT 3 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08359 State of Maryland / Department of Health and Mental Hygiene 2007 36540 John Clark Wagner Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day October 27, 2007 1304 hrs John C. Wagner Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rethesda 5324 Albemarle Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Country)Michigan **Funeral** Min Days Hours Months 03/15/1931 Director 76 382-30-5116 1X M Yrs 2 F Usual Residence of Decedent 10d. Inside City Limits IOc. City, Town or Location 10a State 10b. County any 1 X Yes 2 No s 23a or 28a-f show s notified at once. Bethesda it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland virtuent of Health and Mental Hygiene.

retant: If item 27 is marked other than "marker" or other traumatic marker. Maryland Montgomery Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20816 5324 Albermarle Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? ( Specify Yes or No 12. Was Decedent Ever in U.S Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 X Married 1X Yes Specify: White Yes 2X No specify: If Yes, Give Year 1953-1958 Widowed Divorced 3 16h. Kind of Business/Industry ð 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) pleted Elementary/Secondary (0-12) College (1-4 or 5+) Law 5+ Attorney Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Muriel Maude Clark John Francis Wagner Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ Marilyn Wagner / Wife 5324 Albermarle St. Bethesda, MD 20816 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 10/30/2007 Falls Church, VA National Crematory Donation 5 Other Specify 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the di Between Onset and **Physician** failure. List only one cause on each line. Death Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): B and Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -To the Hospital or Attending Physician. The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Month Day Year 3 Ectopic pregnancy 3b. Was decedent pregnant in the Live birth Fetal death signed by the attending be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✔ No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available Completed 24a Was an certificate has been ector, page 2 should prior to completion of cause of autopsy performed? death? page 2 1 🗸 Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical funeral director, Division of Vital Be Other<sub>4</sub> Residence 6 V Other: Scene examiner? Nursing Home 5 Hospital: DOA Inpatient 2 ER/Outpatient 3 this ٩ 1 Yes 28d. Describe how injury occurred 28a. Date of Injury FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject shot self Certification: FOUND: Yes 2 V No Natural Pending Oct 27, 2007 1230 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 6324 Albemarle Street, Bethesda, MD 3 V Suicide Could not be determined (Specify) Single Family Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

within 24 hours after death.

To the Funeral Director: completely filled in by the fi

Registrar

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month Day Year)

and manner stated

Assistant Medical Examiner

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

2007

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

October 28, 2007

07-08551 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gail D. Wiebrecht Certificate of Death Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month Day November 3, 2007 1218 hrs Medical Examiner Gail Darlene Wiebrecht 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Washington Maugansville 17804 Alpine Drive 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) 220-58-3166 Months Davs Hours Min Director MD 02/27/1952 55 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 X Yes 2 No 28a-f show Maugansville MD Washington notified at once. with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21767 US 17804 Alpine Drive Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be death v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married Yes Specify: White Yes, Give Yea Yes 2 X No specify: Widowed 4 Divorced the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natur: or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Tavern 10 Owner 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryetta Mae Rutherford Robert Lee Rice, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) John R. Wiebrecht / Husband 17804 Alpine Drive, Maugansville, MD 21767 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Salem Evang, Luth. Ch. Cem. 11/08/2007 Boonsboro, MD tant: Donation 5 Other Specify 21. Signature of Funeral Service I cen 22. Name and Address of Facility Gerald N. Minnich Funeral Home Street, Hagerstown, MD 305 N. Potom<u>ac</u> 23a. Part I. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical AMENDED #23a,27.perME,g875. YUNPENDED attending physician for use as the burial -Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? ✓ Yes 2 death? No 1 🗸 Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursina Home 5 Inpatient 2 this 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 1 X Natural Yes 2 No 24 hours after death. Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. November 4, 2007 NO 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD.

State Registra

32. Registrar's Signature

Aspens.

31. Date filed (Month, Day Year)

DHMH 17 Rev 1/2001

Registrar

NITMES OF

NOV 0 2 2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan	•	artment of H <i>rtificate of L</i>			g. No.	36543
	Physici	an	1. Decedent's Name (First, Middle, Last, Goldic M Wi					2. Date of Death Month	Day Year 27 2007	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	OCIDEA	4c. County of Dear	
		Ť	Coastal Hospice At	-The bake		Salisbu			Wicomic	0
ı	Funeral Director		213-14-9399	7. Age (In yrs.) 7. Age (In yrs.) 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12/25/1	Year) Co	hplece (State or Foreign untry) ryland
	land bw		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Mary	tor	Maryland Worcest	er Si	now Hi	11				1 ☐ Yes 2 ☐ No
	ith the	Direc	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23a	rail	6654 Snow Hill R		C 10	21863	anania Origin? (Sn	acify Vas or No-	USA 14. Race - Ame	nican Indian
920	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event. If a Medical Eracid at missible indiffied at ODGs.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, Whit	
21215-0036	thin 72 ho e. an "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done o DO NOT use retired	ation furing most of work )	ing	6b. Kind of Business	Industry
2	led wil hygien her th		9 17. Father's Name (First, Middle, Last)	0	acc	ounting	18 Mother's Nam	e (First, Middle, M	Moore Busi	ness Forms
Maryland	d be fi	o Be	Stanford Noble S	hocklev					onneville	
ary	12 should be 1 and Mental I Is marked of reumatic eve	၉	19a. Informant's Name/Relationship (Ty				and Number or Rui	ral Route Number,	City or Town, State,	
	end 2 salth a n 27 ls		Linda W. Ward/dau						L, MD 2186	
Baltimore,	Peges 1 ment of He ant: # Iter lury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	isbury	osition (Name of matory or other place Cremator	e) Cy 10/3	0/07	Salisbury	, MD
Balt	Depart Import any in		21 Signah of Fun ral Service Licens	1	FSP	HÖT15WAY 501 Snow	Funeral Hill Rd.	Home Prof , Salisbu	fessional ury, MD 21	Association 804
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death	n. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	METAS		TIC S	SARCO.	4A - P	RLVIS	Onsor and Boats
	/Medical Examiner		Todaling in doubly	Due to (or as a consequ	uence of):					
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	uence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	sono of):					
58760,	icate be executed physicien and s the burial-transit	aiE		Due to for as a consequ	derice ory.					
_	ifficate g phys	ledicai		J						
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	juires that t n signed by lid be detad	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	s 2 3 P	o the cause of death?
Records,	The law requir te has been si age 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
ital	entifica octor, p	BeC	25. Was case referred to medical examiner?					th (Check only one		
of <	ding Physician: The I h. After this certificate ha funeral director, page	္	1 Yes 2 No	fospital: 1 Inpatient 2 2	ER/Outpatie		4   Nursing no	ome 5 Reside	nce 6 Other (Spe	ocify)
OU	ding h. After funer	tion	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □ No	200. 2000.00 110	W Injury Coodinou	]
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certification in the funeral director, completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory, office	Ī	28f. Location (Str City or Town	reet and Number or P , State)	ural Route Number,
	To the Hospitel within 24 hours To the Funeral completely filled	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.						
	To the within ?	Me	29b. Signature and title of certifier			29c. License		ŀ	d. Date signed (Mon	•
)	5					_   D	00584	110	10-2	7-07
	2n		30. Name and ad ress of person who co.  GHUAM WAY  31. Date filed (Month, Day, Year)  OCT 3 0 2	empleted cause of death (Item	1 23a) (Type,	Print) OSPICIE	P.0 130	× 1733	SALISBI	(My woz 1802
ga.	Sta Registr	te ar	31. Date filed (Month, Day, Year) 0CT 3 0 2	32. Registrar's Signa	ture .	boile				,

ans 3 completed cause of death (Item 23a) (Type, Print) Hwy Suite 410 Waldorf, MD 20601 ett 31. Date filed (Month, I Day, Year) 32 Registrar's Signature State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2007 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 13, 2007 **Physician** 9:45 A M Raymond Cecil Ashby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Harford Memorial Hospital Havre De Grace 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Q 2 Yrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** 1**X** M 2□ F California 83 553-24-4779 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Tes 2 No Director Aberdeen Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 1121 Old Philadelphia Road #26 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?

1X Yes 2 No 1941
If Yes, Give Year or Dates: 1945 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Systems Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fdith Wines Ernest Walter Ashby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 524 Bear Branch Road Westminster, MD 21157 Brian Alan Ashby, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: if any injury or pace. Metro Crematory Inc. 11/14/07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatura Funeral Service Licensee 22 Name and Address of Facility Of Maryland, Inc. Inomas Gregor 299 Frederick Koad Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acquired Physician 10 days ommunity disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? TIAS 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 86 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 2 ☐ Accident 3 Suicide

/Medical Examiner use as the burial-transit RAVHOVI Division death. s efter death filled in by ō within 24 hours e To the Funerail completely filled

other than "

should be to ad Mental I

and

item 27

6

Certification: To 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 29a. Certifior \*Ecritiving Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

5+1

Registrar

31. Date filed (Month, Day, Year) State

MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Poppe

Haford

DU065827

Memorial Hosp.

			State of Maryland /  1- State Registrar	-	rtment of H		d Mental Hy	giene	2007	36547
			Decedent's Name (First, Middle, Last)	-			2. Date of D	eath	_ 0 0 7	3. Time of Death
	Physicia /Medic		Henry Ansley				Novem	ber 5	2007	1:57 PM M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or		eath	4c.	County of Death	
			Anne Arundel Medical Center		Annapol:				Anne A	
	Funeral Director		5. Social Security Number 6. Sex 1 № M 2 □ F 7. Age (In yrs. last) 75	Yrs.	If Under 1 Year Months Days	If Under 24 F Hours M	8. Date of Bi (Month, D May 5,	ay, Year)	Cou	place (State or Foreign ntry) unk
	pu ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	wn or Lov	eation					10d. Inside City Limits
	anyla shov ed at	5		polis						1 □Yes 2□No
	the M	Director	10e. Street and Number	POIL	10f. Zip Code			10a. Cit	izen of What Cou	
	with la or t be r	ä	900 Van Buren Street		· ·	21403			USA	
	Jeath	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	13. V			' (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Ameri	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fur	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Yes, specify Cuba	Specify:	geno Hican, etc.)		Black, White, Specify: W	nite
3	2 hour	ted t	15. Decedent's Education	Ba. Deced	ent's Usual Occup	ation	unk	16b. K	ind of Business/Ir	ndustry unk
213	vithin 7% sne. than "na e Medi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give I life. D	kind of work done o OO NOT use retired	during most of (	working			
2	al Hygie I other I	Be Co	unk unk  17. Father's Name (First, Middle, Last)		unk	18. Mother's I	Name (First, Middle	e, Maiden	Surname)	unk
Z	should by marked marked	To	19a. Informant's Name/Relationship (Type. Print) 1	9b. Mailin	g Address (Street a	and Number or	Rural Route Num	ber, City c	or Town, State, Zi	p Code)
N	and 2 sealth ar		Anne Arundel Medical Center	2001	Medical	Parkwa	y Annapol	ıs,	MD 2140	1
בי בי	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 ₩ Other (Specify) in state	of Dispos tery, crem	sition (Name of natory or other place	e)	Date	20c. Lo	ocation - City or T	own, State
Dalimon	permit. F Departm Importar any Injur		21. Signature of Funeral Service Licensee Ronald S. Wade, Director		Name and Addres ate Anat ltimore.		ard 655 W	. Ba.	ltimore	Street
ř			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	o not ente	er the mode of dyin	g, such as car	diac or respiratory			Approximate Interval Between Onset and Death
H	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  A TETERIA CLE  Due to (or as a consequence)	Sold of):	CLAN	10145	cular Pi	Sea.	SP	years
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):						
	ecuted nd transit	Examiner	that initiated events c							
00,00	cate be executed physician and the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence	:e ot):						
00	tificate g phy as the	ledic								
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	very Day Year
٦,	es that th gned by be detac		Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause give	en in Part I.		/		the cause of death?
colus,	w requir	eted	Aug To	1	1) these				24b. Were aut	opsy findings available
ב ב	The lay	Completed by	Nimm (Cz)				— aut per 1∐ Yes	opsy formed? 2 No	death?	ompletion of cause of
N I C	Iclan: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:		Oth	OF.	Death (Check only			
5	Phys this al dir	6	1 Tes 2 Inpatient 2 ER/	Outpatient b. Time of	3 DOW	4 LI Nursin	g Home 5 ☐ Res			ify)
5	ding th. : After : funer	tion	1 ☐ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	28c. Injur Worl	k? Yes 2∐No			,	
	or Atter after deal Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Could not be determined determined building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location City or To	(Street ar own, State	nd Number or Ru e)	ral Route Number,
	Hospital	edical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowler 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or in	occurred at the tire	me, date and p ppinion, death o	lace, and due to the	e cause(s ∍, date an	s) and manner as od place, and due	stated. to the cause(s)
	To the within To the somple	Mec	29b. Signature and title of certifier	-	29c. Licens	e number		29d. Da	ate signed (Month	, Day, Year)
			Panllin Worl	m	X DO	155	2	NOI	veinber	5 2007
			29b. Signature and title of certifier  20 Name and address of person who completed cause of death (Item 23 Y 23 31. Date filed (Month, Day, Year)  32 Registrar's Signature  NOV 1 5 2007	a) (Type, I	een stu	ry Rd	HyaTIS	44 He	o MAD 2	0751
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 5 2007	Solo	ule)					

DHMH 17 Rev 1/2001

NOV 1 5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Hanorah Katherine Alseth November 2007 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year)
Oct 18, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕁 F 99 1908 Director Maryland 215-03-4864 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road #303 21286 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: white þ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 h and Mental Hygie 7 is marked other the <u>stenographer</u> Enoch Pratt Library 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Bernard Fitzpatrick Mary Missouri Hosmer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health a Important: If item 27 is any injury or other trau once. John Prendergast/grandson 618 Pearl Point Court Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee
Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part. Enter the discase, or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER, METASTATIC COLON MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to in moral cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine sician and burial-trans Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Be Completed Certification: To

Division or Vital Records, Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

the Funeral Director; A

edk					1 ☐ Yes 2	No 3 Probably 4 Unknown		
Completed					24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No		
Ð	25. Was case referred to medical			26. Place of De	eath (Check only one)			
To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	Sether (Specify) HOSPICE		
ation:	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury			
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		home, farm, street, fac cify)	tory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )		
Medical (					, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)			
Me	29b. Signature and title of certifier	_ \_		29c. License number	29d. Dat	e signed (Month, Day, Year)		

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

D64395

NOVEMBER 12, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NCHARLES ST, SUITE 209 BALTIMORE, MO 21204 DOBERMAN, MD 6565

the within 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 17 per fb 873 11-15-07 vt.
State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 0 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day MARSTON\_ 40 Jam Bon 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HOSPITAL 7. CENTER RANDALLS TONN BALTIMENT NONTHOUSS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Director 215-14-5157 86 08/15/1921 MD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits ns 23a or 28a-f shor must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3417 OLD COURT ROAD 21208 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 N Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED FOOD VENDING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even ISIDORE ISIDOR ADLER MARIAN MOLITZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DORIS ADLER WIFE 3417 OLD COURT ROAD - BALTIMORE, MD 21208 Health tem 27 i Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery crematory or other place)
BETH TFILOH 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2007 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepses /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dauss (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of eause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Effasis 1□ Yes 2 DNo completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Impatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director. 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 1950 > 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENA OR CANDO State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No.2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death November KATHLEEN **Physician** 1:54 [1,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL BALTIMORE N/A 8. Date of Birth (Month, Day, Dec 20, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 246-32-8683 1 □ M 2 F Months Days Hours 80 1926 Director North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nit. Pages 1 and 2 should be filed within 72 hours after death with artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or Injury or other traumatic event, the Medical Examiner must be r 21201 833 West Pratt Street Apt 715 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Junius Brewer Mary Odun ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen B. Christman, Daughter 3808 4th Street Brooklyn, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any Injury or 11/14/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Like see
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSI **Physician** /Medical Examiner 7 days ESCHERICHIA COLI BACTERFIMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an After this certificate has autopsy performed? 'es funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 🗌 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined

Division or Vital Records, P.O. Box 68760,

4 hours after death. Funeral Director: / filled in by the within 24 hours a

4 ☐ Homicide 29a. Certifier (Check only one)

3 ☐ Suicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certife

29c. License number

Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

**RES-000** 

November 11,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Opl S. Hanover Street
CVATI CINAL ALONG MD-HARBOR HOSPITAL, Baltimore, MD 21225 SVATI SINGLA-LONG, MP-HARBOR HOSPITAL 31. Date filed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical

NOV 15



32. Registrar's Signature ORIGINAL

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) November ELIZABETH BURTON 2007 12 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 K F 216-58-0442 56 21,1951 Maryland Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count 1 ☐ Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21060 U.S.A. 801 Marigold Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Child Development Day Care Provider 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Viola Howard Torrence Harry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Marigold Road, Glen Burnie, Maryland 21060 Mark Burton (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 11-14-07 Bayview Crematory Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) YOCARDIAI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? YPERTENSION 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

Be

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 273 is marked other than "natural", or Items 23a or 28a-f sho, any inJury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

RUZMENT

attending physician and for use as the burial-transit signed by the attending I certificate has been s rector, page 2 should

The law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Hospital or Attending Physician:

Examiner Physician/Medical Completed by Be To the Hospital Committee within 24 hours after death.

To the Funeral Director: After this committeely filled in by the funeral directors. မ Certification:

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

27. Manner of Death

1 Natural
2 ☐ Accident

29a. Certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

am

D0061832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 HOSPITAL DR. JAIN) MD

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last Physician bourne NOVEMBER 03:29 Haron 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SINAL BALTIMOR ITY MOSPITAL OF BALTIMORE If Under 1 Year 8. Date of Birth (Month, Day Year) 10-2-1985 Year If Under 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Country) MD **Funeral** Months 213-17-4280 22 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 Yes 2 No MD Funeral Director fimore -28a-f 10g. Citizen of What Country? 10e. Street and Number tems 23a or 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Kind of Business/Indus Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) atonsville (Give kind of work done during most of working ine DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College tudent ath 18. Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last) Be Bourne eonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address Street and Number or Rus Route Number, City or Town, State, Zip Code) Leonard + Margaret Bourne Harents 681 MD henbern Koad 20c. Location - City or Town, State Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lisensee reene Funeral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** ARDIO MYOPATHY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. End Understand Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown DYSTROPHY MUSCULAR Completed 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE MEAKT autopsy performe 1 ☐ Yes 2 ☐ No 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MABBO 000

DHMH 17 Rev 1/2001

Registrar

OF

BALTIMORE

SIAVAI MOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TALWAR

NOV 1 5 2007

31. Date filed (Month, Day, Year)

Registrar

Begett

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 1/3, 2007 William P. Bortner 3:15 A.M 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days Hours 216-62-6666 1**y** M 2□ F 56 31,1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County Yes 2 No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1111 Roland Heights Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 200 No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Engineer Engineering Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lewis Henry Bortner, Jr. Margaret Evelyn Loyn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Bortner Mother 1111 Roland Heights Avenue, Baltimore, MD 21211 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 11/17/2007 Pikesville, Maryland 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LASTOMA 0 Due to (o as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

28a-f

23a or pe

items

9

"natural"

than

Health and Mental Hygic em 27 is marked other

Pages 1

Department of Health and Mental Hygi important: If item 27 is marked other any injury or other traumatic event, t

Maryland 21215-0036

Baltimore,

Box 68760.

P.O.

Division or Vital Records,

notified

**Examiner must** 

Funeral

burial-trans the for use à

Examine

Physician/Medical

þ

Completed

Be

Certification: To

1 Natural

2 Accident

4 🗌 Homicide

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier (Check only one)

page 2 s funeral director, After t

certificate be executed e Hospital or Attending I 24 hours at er death. e Funeral Director After filled in by To the l within 24

DHMH 17 Rev 1/2001

State Registrar

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29c. License number

1 ☐ Yes 2 ☐ No

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) November 13, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Balto. M. 20204

6701

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 Could not be determined

32. Registrar's Signature

**ORIGINAL** 

			Plea	se Type or											.egil	ble.		
		For State		State	of Ma	arylan	-	oartme e <i>rtifica</i>				/lental			2.0	O ==	0.0	
		State Registrar  1. Decedent's Nam	ne (First Middl	e (ast)				erunca	le oi i	Deam		2. Date of		g. No.	20	U/	3 Time	555
Physicia		Joan	10	Land								Month	1	Day	7	Year	12:1	8 A <sup>M</sup>
/Medic Examin	Mary I			n, give street and nu	ımber)			4b. City	, Town, or	r Location	of Death		11/01	-	County	of Death	104.1	10 /1
X	Υ'	Union	Memori	ial Hospi	tal			Ba	ltimo	ore					N/A	A		
Funeral		5. Social Security N		6. Sex 1 ☐ M 2 🔀 F	7. Age	e (In yrs. I	as <i>t birthd</i> a Yrs.	y) If Und Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Monti	of Birth h, Day,	Year)		9. Birthp Cour	lace (State	or Foreign
Director	(	213-36-7 Usual Residence o		<del>X</del>		68	115.					Mar.	2,	1939	) M	Maryl	and	
yland low at		10a. State	10b. County			10c. City	, Town or	Location								1	0d. Inside	City Limits
72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ctor	Maryland		N/A			Bal	timor	e, Ma	aryla	ınd						TXXY =	es 2 No
ith th	Director	10e. Street and Nu	ımber						ip Code				10	0g. Citiz	en of W	Vhat Cour	ntry?	
s 23a	eral		Hickory	Avenue	and and I	Tues in 111	S 14		1211	lia-ania O-	-1-1-2 /0-	:6. V	ar Na	US		o - Amorio	an Indian,	
tter de ritem iner r	Funeral	<ol> <li>Marital Status</li> <li>Never Mari</li> </ol>	ried 2□ Marı	12. Was Ded Armed F ried 1 ☐ Yes	orces?		5.	3. Was Dec If Yes, sp		an, Mexica	in, Puerto	Rican, etc	c.)	'		k, White,		
urs al	þ	3 X Widowed		If Yes, G	ive			1 ☐ Yes	2⊠ No	Specify.	:				Specify	· Whi	te	
72 ho	Completed	(Spe	15. Deceden	t's Education st grade completed	)		16a. Dec	cedent's Us ve kind of v . DO NOT	ual Occup	ation during mos	st of worl	kina	Ų.	16b. Kin	d of Bu	isiness/In	dustry	
/ithin ne. han "	mpl	Elementary/Seco		College		i+)						3			Sub	Sho	n	
illed w Hygie ther ti	Ŝ	17. Father's Name	(First Middle	( ast)			Ω	ounter	wor		er's Nam	ne (First, M.	iddle. N	Maiden S			<u>-</u>	
d be tental	o Be			Edgar Sn	vder	:						Arnol			, , , , , , , , , , , , , , , , , , , ,	.0,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insperment of Health and Mental Hygiene. Inspertment of Health and Mental Hygiene. An analysis is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	T <sub>o</sub>	19a. Informant's N				-	19b. Ma	iling Addre	ss (Street					, City or	Town,	State, Zip	Code)	
and 2 salth a 27 is		Robin	Krause	Daugh	ter		4	1233 F	licko	ry Av	enue	e, Bal	tim	ore,	, ME	212	11	
es 1 gof He filtern		20a. Method of Dis	•	3 Removal from	State	20b. P	lace of Dis emetery, c	position (N rematory o	ame of other plac	ce)		Date	1	20c. Loc	ation -	City or To	wn, State	
Pag ment lant: I		4□Donation	5 Other (S	Specify)	Juliane	Me	_	Cremat				0/07		Cato	onsv	<i>i</i> lle	, MD	
permit Depart Import any in		21. Signature of Fi	uneral Service	Licensee		- 1		22. Name				z Fur	era	ıl Ho	ome.	Inc	212	211
40=60		ALA 220 Parti Fila	$\gamma\gamma\gamma$	complications that		the death	Do not o					z Fur Balti			Mary	zland	Approxim	
		shock, or bea	art failure. List	only one cause on	each lir	ie.	Vin assess				s cardiac	Or respirat	ory arre	351,			Interval B Onset an	etween
Physician /Medical		disease or condition resulting in death)	on			YIC.	negative of):	rt a	iseas	se						_	104	ears
Examiner				30.	92.0	mall	1.01	lowe	cenv	Cino	ma.	9					19 in	ionth's
	ner	Sequentially list co if any, leading to ir cause. Enter Unde Cause (Disease or	onditions, mmediate erlying	D		a consequ		101710	1	CHIL	1116	-					Cit	1001111
executed in and ial-transit	Examine	Cause (Disease or that initiated event resulting in death)	S	c												- 1		
n certificate be executed anding physician and use as the burial-transit		resulting in death)	Last	Due to	(or as	a consequ	uence of):											
icate physi	Physician/Medical			d												-		
eath certif attending for use as	J/Me	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, or										2:	3d. Dat	te of deliv	erv	
death	icia	in the past 12		4□Preg	nant at	2 ☐ Fetal time of d		3 □Ectopic 5 □ Other (		у			_			nth	Day	Year
at the by the tache	hys	9 Unknown	1	9□Unk	nown													
The law requires that the death certificate be to has been signed by the attending physicial bage 2 should be detached for use as the bur	by F	Part II. Other signi	ificant conditi	ons contributing to	death bi	ut not resu	ulting in the	underlying	cause giv	en in Part	I.	23e.					he cause o	,
requir een s													1 🗆 Ye	es 2L	] No	3 Prol	oably 4 L	Unknown
e law has b	Completed												Was ar autops perform	V	24b. \	Were auto	psy finding mpletion o	s available cause of
				: 1								1□`	Yes 2	2 ⊈No		1 ☐ Yes	2□No	
Physician: r this certificaral director,	o Be	25. Was case refe examiner? 1 ☐ Yes 2 ☐	/	Hospital:	Inpatie	unt 2 🗆	ED/Outpot	ient 3∏ [	Oth	or.		th (Check of			Пои			
g Phy er this	-1	27. Manner of Dea	th	28a. Date	of Inju	ry	28b. Time	e of	28c. Injur Wor		ursing H	ome 5 🗆 28d. Desc					<u>y)</u>	
ath. or: Aft	Certification:	1 ☑Natural 2 ☐ Accident	5 ☐ Pendir investi	gation	nth, Day	y rear)	Injun	M		Yes 2 □	]No							
ir Atte ter de irecto	tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could detern	singd   Zot. Flat	e of injuding, etc	ury - At ho c. (Specify	me, farm,	street, facto	ory, office			28f. Locat	tion (St.	reet and n, State)	l Numb	er or Run	al Route N	umber,
oital ours afi									1 1 1 1 2									
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)		ng Physician: To th Examiner: On the and ma	basis of	f examina												e(s)
o the vithin (	Mec	29b. Signature and	d title of certifie		IIII SI	iled.		2	9c. Licens	e number			25	9d. Date	e signed	d (Month,	Day, Year,	)
F S F Ö		· Va	MUM	Mach	,	M.D	),		AT 2	4389	146		N	lover	nb	er 8	, 20	07
2		30. Name and add	ress of person	who completed cau	use of d	eath (Item	23a) (Typ				•		<u> </u>					
Ų ·		celeste	chery	11 L. QUI	an;	zon,	M.D	e, Print)	lion	Mem	Orid	1 140:	spit	01,	Ba	Itim	ore, I	ND
Sta		31. Date filed (Mor	nth, Pay, Year)	2007	Registra	ar's Signa	ture	all s										
Registr	ar	***		A STATE OF THE PARTY OF THE PAR	-	dan.	0											

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	/larylan		artment of F rtificate of		Mental Hy	giene Reg. No. 2 () (	7	36556
и			Decedent's Name (First, Middle, I	Last)					2. Date of De	ath		3. Time of Death
9.	Physici /Medic		Margaret Bo	owden					Novemb	oer 12,20	Year 007	12:30 P M
	Examin		4a. Facility Name (If not institution, g		r)		4b. City, Town, o	or Location of Dea	ath	4c. County		
	24		12202 Burncourt F				Timoni		0 0 0 ( 0)		alti	
	Funeral Director		5. Social Security Number 6 219–18–7760	. Sex 7. A	age ( <i>in yr</i> s. i	as <i>t birthd</i> ay) Yrs.	Months Days	Hours Mir	1. (Month, Da		Cou	place (State or Foreign ntry) 1and
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation		0:		— Т	10d. Inside City Limits
	Maryla f sho	ō	MD Balti	imore		imoníu						1 ∐Yes 2X No
	r 28a- notif	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Cou	ntry?
	h with	al Di	12202 Burncourt	Road #101	1		2109	13		USA		
	ems deat	ner	11. Marital Status	12. Was Deceden	t Ever in U.S			lispanic Origin? (	Specify Yes or No	- 14. Race	e - Americk, White,	can Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married	1 ∏Yes 2 <b>X</b> If Yes, Give	No		i∏Yes 2∏XNo	Specify:	nto riioan, cto.,	Specify.		hite
15-0036	hours tural' al Ex	q pa	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates	:	16a Deced	lent's Usual Occu	nation		16b. Kind of Bu		dustry
Ç.	within 72 ene. than "na he Medic	Completed	(Specify only highest	grade completed)	. 5.)	(Give	kind of work done OO NOT use retire	during most of w	orking	Tob. Kind of Bu	3111033/111	dustry
7 7	d with giene er tha	mo	Elementary/Secondary (0-12)	College (1-4or 2	(5+)	Pay	roll Ass	istant		Depar	rt o	f the Navy
yland	be filed Ital Hygi Id other event, tl	Be (	17. Father's Name (First, Middle, La	•					ame (First, Middle,	Maiden Surnam	9)	
	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic es once.	၉	George Schumann						yn Baker			
Ma	d 2 sh th and 7 is n traun		19a. Informant's Name/Relationship						Rural Route Numb		State, Zij	o Code)
	1 and Healt tem 2		Tracey A. Bowden  20a. Method of Disposition	1, D.D.S./s	20b. Pl	ace of Dispos	sition (Name of	i	nkton, MD	21111 20c. Location -	City or T	own, State
baltimore,	ages ent of nt: If if		1 ☐ Burial 2 🕅 Cremation 3 4 ☐ Donation 5 ☐ Other <u>(Soe</u>	Removal from State	e Met	emetery cren cro Cre	matory or other pla ematory	ce) No.	7. 13, 007	Balt:	imor	a MD
	mit. Foortar		21. Signature of Funer Price Lice			_22	. Name and Addre		me_of Dul			
ñ	a in De		1-3	chael J. I	Flagle	10	M. Pado	nia Road	ne or Dul 1 Timoniu	im, MD 21	1093	, inc.
			23a. Part1. Enter the disease, or each	implications that cause ily one cause on each	ed the death line.	. Do not ente	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	m <sub>y</sub>	low	21	retert	-				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):						÷0
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequ	ience of):	J. Was	6XZ			1	UNES
/	uted Insit	mine	Cause (Disease or injury	5.0	22.2	ionoc oi).	<i>y</i>					120008
, -	execting and items of the section and the sect	Examiner	that initiated events resulting in death) Last	cDue to (or a	s a consequ	ierica of):						Jan 2
09/90	icate be executed physician and the burial-transit	dical		d								
D	ertifica ing ph e as th	Med	IF FEMALE:									
ŏ D	death certifi e attending d for use as	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 🗆 Fetal	death 3	Ectopic pregnanc	у		23d. Date Mor		ery Day Year
5	w requires that the death certifit been signed by the attending p should be detached for use as	Physician/Me	1 □ Yes 2 No 9 □ Unknown	4∐Pregnant 9∐Unknown		eath 5L	Other (specify) _					
ř.	The law requires that the ate has been signed by the bage 2 should be detache	h Ph	Part II. Other significant conditions	s contributing to death	but not resu	ılting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	obacco use contr	ibute to t	the cause of death?
Records,	quires in sign	d by	H3P						. 1 <b>)X</b>	Yes 2□ No	3 ☐ Pro	bably 4 ∐Unknown
ဂ ဂ	aw rei is bee 2 shoi	Completed	AFIF	5					24a. Was		Vere aut	opsy findings available
	The I	L O	Cac	12000 5	es fre	176			· autor perfo	ormed? d	leath?	ompletion of cause of 22 No
N N	sian: ertifica ctor, I	Be C	25. Was case referred to medical examiner?	U. A. A				26. Place of D	eath (Check only o	- ,		
5	Physician: r this certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 Inpat		ER/Outpatien	1 30 00		Home 5 Resi			fy)
	fing F	ion	27. Manner of Death  1 Natural 5 Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2 ⊟No	28d. Describe	how injury occurre	∌d	
VISION	Attending ir death. ector: After by the fune	icat	2 Accident investigat 3 Suicide 6 Could not	be 290 Place of it	niury - At ho	me. farm. stre	eet, factory, office	res 2 🗆 NO	28f Location (	Street and Number	er or Rui	al Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determine	building, e	etc.'(Specify	)	, , ,		City or To			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the besi	at of my know	wledge, death	occurred at the ti	me, date and pla	ce, and due to the	cause(s) and ma	nner as :	stated.
	the Hi nin 24 the Ft	Medical	one)	aminer: On the basis and manners		non and/or in			curred at the time,			, ,
	To Tool	2	29b. Signature and title of certifier	(1)		u.s	29c. Licens	se number	1	29d. Date signed	(Month,	Day Year)
	`		I her o	Millen			U	ts ld	/	W	LA.	101
	10		30. Name and address of person who Dr. Kenneth Koch					Timon:	ım MD 91	003		
	Sta	te	31. Date filed (Month, Day, Year)			ture		TTHOUT	III CI	U33		
	Registr		MALT	5 2007	REGISELO.	S. P.	MARIE S					

			For State Registrar	State of Maryla		artment of I			giene Reg. No. 2 (	007	3655
F	Physicia	_	Decedent's Name (First, Middle, La Baby Girl Burch					2. Date of De Month	Day	Year	3. Time of Death
Fı	/Medic Examin uneral rector		4a. Facility Name (If not institution, given the Johns Hopk 15. Social Security Number 16.	re street and number)	s. last birthday) Yrs.	Ber		ity	4c. Count th ay, Year)	9. Birthpl	lace (State or Foreig
		ector	Usual Residence of Decedent  10a. State 10b. County  MD		ity, Town or Lo	re		1	10g. Citizen o	10	0d. Inside City Limits
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	or Items 23a or 3 niner must be n	<b>Funeral Director</b>	10e. Street and Number  2837 Erdman Aver  11. Marital Status  1 ☒ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify Cu	21213 Hispanic Origin? (Sban, Mexican, Puerl	pecify Yes or No to Rican, etc.)	)- 14. Ra BI	USA ace - America ack, White, e	an Indian, etc.
vithin 72 hours and	han "natural", c e Medical Exa <u>n</u>	Completed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	1 ☐ Yes 2 🕅 No edent's Usual Occu e kind of work done DO NOT use retin	upation	rking	Spec		dustry
y talls 2 outd be filed w Mental Hygie	arked other thatic event, th	To Be Col	none 17. Father's Name (First, Middle, Las	·	none	unk		awn Buro	h		
ges 1 and 2 sh t of Health and	If Item 27 is m or other traum		19a. Informant's Name/Relationship  Johns Hopkins Hos  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 [	spital 20b.	600	-	e Street ]		-	21287	
permit. Pa Departmen	Important: any Injury once.		4 □ Donation 5 ☑ Other (Special Service Local Service Loc	Wade, Directo	B	altimore.	ress of Facility Comy Board MD 2120	01		nore S	
/M	sician edical miner		2 a. Part1 Enter the discase, or c. I shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the der one cause on each line.  a.  Due to (or as a conse	pre	nter the mode of dy	ying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	physician and the bunal-transit	dical Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Under thing Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a consect.  Due to (or as a consect.)							
the death certif	<b>To the Funeral Director:</b> After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the form the funeral director is a second to the form of the form	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnan □ Other (specify)	су			Date of delive	ery Day Year
equires that	en signed by	by	Part II. Other significant conditions	contributing to death but not re	esulting in the u	underlying cause g	iven in Part I.	11	tobacco use co Yes 2 No		ne cause of death? pably 4 ∏Unknow
in: The law	ificate has be or, page 2 sh	e Completed	25. Was case referred to medical				26 Place of Do	24a. Was auto perf 1 Yes	opsy ormed? 2 No	b. Were auto prior to co death? 1 ☐ Yes	psy findings availabl mpletion of cause of 2 No
ysicia	s cert directa	0 8	examiner?	Hospital:	☐ ER/Outpatie	ent 3 DOA	thor:	Home 5 ☐ Res		Other (Specif	·
ottending Ph death.	ctor: After th	Certification: T	27. Manner of Death  1 SANatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	De 280 Place of injuny - At	28b. Time Injury	M 1	☐Yes 2☐No		how injury occ		al Route Number,
ospital or A	uneral Dire		4 Homicide determined  29a. Certifier 1 Certifying F (Check only 2 Medical Exc	hysician: To the best of my k	cify) nowledge, dea	ath occurred at the	time, date and plac	e, and due to the	own, State)	manner as s	stated.
o the Hithin 24	o the F	Medical	one)  29b. Signature and title of certifier	and manner stated.	Tidadir ditaror		nse number		29d. Date sig		
μž	⊢ŏ		ME	) IMP		R	ES-000		Mo	renbe	19,200
	Sta		30. Name and address of person who Marum H. Sn 31. Date filed (Month, Day, Year)		Dorth		Street	Bulton	oren M	10 2	1287

State

Registrar

NOV 1 5 2007

Bear It Speak

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 8, 2007 Month 2:00 PM M William J. Bramer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, Days Hours 1 ☑ M 2 ☐ F Sept 27, 1932 Maryland 219-28-2813 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2☐ No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 2504 Red Maple Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced **'**51**-**54 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 technician electrical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Bramer Hedwige Ida Garlichs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Bramer/spouse 2504 Red Maple Drive Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4MDonation 5 ☐ Other (Specify) 21. Signature truneral Service Hoensee Waste, Director State Anatomy Board 655 W. Baltimore Street Sell Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VASCULAR PERIPHERAL DYEARS Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STENCE REMAL 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Box 68760 o Records, Division or Vital

GRAMSR

Hospital or Attending Physician: filled in by the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

4 ☐ Homicide

(Check only

31. Date filed (Month, Day, Year)

29a. Certifier

**Funeral** 

**Director** 

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, <u>trannese</u> onee.

**Physician** 

/Medical

filed within 72 hours after death with the Maryland

pe

Pages 1 and 2 should

Maryland

Baltimore,

Completed by Be Certification: To within 24 hours a ter death To the Funeral Director: Medical

> State Registrar

29b. Signature and title of certifier

NOV 1 5 2007

29c. License number D0056296

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 11-8-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ason

Birnbaum MD. 500 Upper Chesapeake Dr. Bel Air, Md. 21019

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please T

type of Print in Black indelible link. Ensure All Copies Are Legible.	
State of Maryland / Department of Health and Mental Hygien 0 0 7	36560
Certificate of Death Reg. No.	

			1 - For State Registrar	State of Marylar		rtment of F		lental Hygien Reg. No		36560
	Dhysisi	-	Decedent's Name (First, Middle, Last	1 0				2. Date of Death Month Day		3. Time of Death
	Physici /Medio			paret K	rowr			NOV 4	2007	1:20 PM
	Examir	ier	4a. Facility Name (If not institution, give	etreet and number) Health Co	onter	4b. City, Town, o	But NI		nne A	irundal
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthp	lace (State or Foreign
	Director		216-18-5632  Usual Residence of Decedent	]M 2₹F	88 <sup>Yrs.</sup>	Month's Days	Hours Mill.	Feb 13, 19	19 Mar	ÿland
	yland Now		10a. State 10b. County	10c. Ci	ty, Town or Loca	ation			1	0d. Inside City Limits
	Ba-fst	ctor	MD Anne Ar	unde1	Seve	rn				1 ☐ Yes 2√ No
	with th	Dire	10e. Street and Number	J Danj		10f. Zip Code	21144	10g. Cit	zen of What Cour USA	itry?
	ms 23	Funeral Director	8283 Quarterfiel	12 Was Decedent Ever in U	.S. 13. W			ecify Yes or No-	14. Race - Americ	an Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland piene. Ir then "naturel", or Items 23a or 28a-f show Ite Medical Ever it et mart be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ፟፟	Armed Forces? 1		Yes, specify Cuba ☐ Yes 2【】No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give k	nt's Usual Occup	during most of work	16b. K	nd of Business/Inc	dustry
212	filed within I Hygiene. other than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	house	ONOT use retired	3)		own home	
nd	othe othe	BeC	17. Father's Name (First, Middle, Last)	- U	nouse	- TIE	18. Mother's Name	e (First, Middle, Maiden		
yla		2	Rufus Irvin Sho					eynolds Cla		
Mai	and 2 sho salth and n 27 Is m		19a. Informant's Name/Relationship (T) Thomas McAuliffe/s	*	_			al Route Number, City o ive Ellicot		,
	8 3 6 g		20a. Method of Disposition	20b. F	Place of Disposi				cation - City or To	
Baltimore,	ment cant: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	ionovarion state		, 6, 6, 10, 6, 6, 6				
Ball	permit. Pages 1 Department of F Important: If ite any Injury or ot		21. Signature of Funeral S, rvice cens	de, Directo	1		ss of Facility omy Board MD 2120	655 W. Bai	Ltimore S	treet
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the deat ne cause on each line.	h. Do not enter	the mode of dyin	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Congest	We	Heart	- Fail	ure		Onsor and Death
	Examiner			Due to (or as a conseq	rdual	Sonl	arctie	DVI		
	pe iis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (hr as a conseq		V	_	Λ Λ	- D.	
	cate be executed physicien and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	LILYOU uence of):	10 (	orona	M MOI	y Elis	ocere
68760,	te be e ysicier e buris	dicai E	· ·	1.						
_		<b>a</b>	IF FEMALE:							
Вох	death certifii attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1☐Live birth 2☐Feta	Ideath 3□E	ctopic pregnancy	,		23d. Date of delive Month	ry Day Year
P.0.	that the dened by the a	nysic	1 □ Yes 2 🗷 No 9 □ Unknown	4⊡ Pregnant at time of d 9⊡ Unknown	eath 5 1 0	Other (specify)				
	res that igned be be deta	by PI	Part II. Other significant conditions con	ntributing to death but not res	ulting in the und	lerlying cause give	en in Part I.	23e. Did tobacco u	se contribute to th	e cause of death?
ord	w require been si should b	ted	Dementia	100 0:1				1 Tes 2	□No 3□Prob	ably 4 Unknown
Records,	K C C	Completed	Daveas	Mediti	<u>(S</u>	<del></del>		24a. Was an autopsy performed?	24b. Were autor prior to cor death?	psy findings available inpletion of cause of
Vital		0	25. Was case referred to medical				26. Place of Death	1 Yes 2 No	1 🗆 Yes	<b>2</b> € No
کر د	Physician: r this certific ral director,	To B	T Tes ZX No	7	ER/Outpatient		4 Nursing no	me 5 Residence	3 □Other (Specil)	0
ono	tending Physicath.	tion:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe how injur	y occurred	
Division of	l or Attend after death Director: /	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he	ome, farm, stree			28f. Location (Street an		l Route Number,
ā	itel or A irs after ral Directled in by			building, etc. (Specif				City or Town, State		
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral complexes the funeral comple	Medicai	29a. Certifier (Check only one)  (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death o tion and/or inve	occurred at the tim stigation, in my o	ne, date and place, a pinion, death occurr	and due to the cause(s) ed at the time, date and	and manner as st place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	\		29c. License	e number	29d. Dat	e signed (Month, I	Day, Year)
1			tool	m	)	De	51596	Nove	mber 9	2007
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Pr	int)	Road 1	03 Glen	Reace.	MD21061
	Sta	te	K. Ambalauav 31. Date filed (Month, Day, Year)	mpleted cause of death (Iten  7845  32. Registrar's Signa	ture	· COOK	TOUG !	US VINCE	Sur 11ce	1001200
	Registra		NOV 1 5 2007	Blocker St.	A STATE OF THE PARTY OF THE PAR					
DUI	MH 17 Dov 1/20	01								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Reg. No. 2 0 36561 Certificate of Death 2. Date of Death 1 1. Decedent's Name (First, Middle, Last) 3. Time of Death -06-2007 **Physician** Jane 9 own /Medical 4b. City, Town, or Location of Death lity Name (If not institution, give street and number) 4c. County of Death Examiner 139 Himos N/A -6 10 OUL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Security Number 7. Age (In yrs last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🕱 F 73 Director May 216-32-0470 2, 1934 Pennsylvania Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 H No Completed by Funeral Director Maryland Baltimore Dundalk the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 21222 871 Mildred Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3₺ Widowed 4 Divorced White other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 12 Years Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r is marked of Be Theodore Heller ٩ Minnie Troll 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Andrew Eiler (Son in Law) 1405 Hidden Valley Ct. Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem, 11/12/2007 Baltimore, Maryland 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Aprendictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Aprendictions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6 PSIS /Medical onsequence of): Due to (or as Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed pertension for use as the burial-trai and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) been signed by the a should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 ☐ No or Attending Physician; director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes PNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 □ No within 24 hours after death To the Funeral Director: the 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 29a. Certifier 🗚 📞 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature #fle of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 192

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

1 5 2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 400 ZZONE 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City Universita of If Under Months If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Davs Hours 1**X** M 2□ F 2, 1931 Pennsylvania 76 Nov. Director 218-28-2129 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Anne Arundel Severn Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21144 United States P.O. BOX 39 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1949 12 Yes 2 No If Yes, Give 1953 11 Marital Status 1 Never Married Married White 1953 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Transportation Truck Driver 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Smith Andrew C. Cozzone, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severn, MD 21144 P.O. BOX 39 Eleanor Cozzone / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov. Date 2, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Permation 3 ☐ Removal from State 2007 Catonsville, MD Metro Crematory 5 Other (Specify) 4 ☐ Donation kley-Ruddick Funeral Home P.A. Crain Hwy. S.E. Glen Burnie, MD 21. Signatur of Funeral Service Licenses 21061 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) month **Physician** /Medical Due to (or as a c sequence of Examiner Sequentially list conditions, if any section to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 s autopsy performed? 1□ Yes 2□No certificate 25. Was case referred to medical 26. Place of Death Check onl one funeral director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Leath 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Box 68760, P.O. Division or Vital Records,

Maryland 21215-0036

Baltimore,

certificate be executed The Physiclan: To the Hospital or Attend within 24 hours after death To the Funeral Director;

filled in by

10 State Registrar

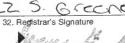
Medical

wi 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baltimore, MD

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		Cer	tificate of	Death	R	eg. No. 2	107	365	563
	Physicia	an	1. Decedent's Name (First, Middle, Last					2. Date of Deat Month	th Day	Year	3. Time of L	Death
Ŀ	/Medic	_	FRANKLIN	F. CORPE	NING			11	12 :	2007	Jali	) М
	Examin	er	4a. Facility Name (If not institution, give	street and number)			r Location of Deat	h	4c. County			
			1860 Quebec Court  5. Social Security Number 6. Se	x_ 7. Age (In yrs. i	act hirthday)	Severn If Under 1 Year	I If Under 24 Hrs	8. Date of Birth		Arun	del ace (State or	Fornian
li-	Funeral Director		243-70-5828 Usual Residence of Decedent	M 2□F 61	Yrs.	Months Days	Hours Min.		Year)	Count	MD	roreign
	/land low at		10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City	y Limits
	Man a-f sh ffied	tor	MD Anne Aru	nde1	Se	vern					1 ☐ Yes	2 <b>X</b> No
	h the	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Count	ry?	
	th wil		1860 Quebec Court			21144			U.S.	Α.		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - America		
Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🟋 Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 ☐ No If Yes, Give Year or Dates:	1	∏Yes <b>XX</b> No	Specify:		Specify			
5-	"nat	ete	15. Decedent's Edu (Specify only highest grad	ucation fe completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	ation during most of wo	rking	16b. Kind of Bu	usiness/Ind	ustry	
12	within 7 ene. than "I he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ram Manag			Federal	Avei	ation	Adm.
d 2	e filed all Hygie other vent, th		17. Father's Name (First, Middle, Last)	4	11051	Lam Hanag	Ī —	me (First, Middle, I				
aŭ		To Be	Robert Corpening				Helen N	lack				
7	2 shoul and M is marl aumatl	F	19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Mailin	g Address (Street		ural Route Number	, City or Town,	State, Zip	Code)	
	1 and 2. Health a em 27 is		Mrs. Clara F. Corp	ening/Wife	1860	Quebec (	Court Sev	vern, MD	21144			
re,	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		20a. Method of Disposition		lace of Disposemetery, cren	sition (Name of natory or other pla	ce) Nov	Date . 28,	20c. Location -	City or Tov	vn, State	
E	Page nent o		1 X Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	•	Nat.Cem	'		t. Myer	. VA		
Baltimore,	permit. Pages. Department of I Important: If Ite any Injury or of	Ì	21. Signature of Funeral Service Licens				1	ingleton			ematio	on
m	Depar Depar Impo		nothern The	mo030.	3 S	ervices :	l Second	Avenue S	W Glen	Burni	e MD 2	21061
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Betw	veen
	Physician		Immediate Cause (Final disease or condition	Mill	tale		elome			- 1	Onset and D	eath
	/Medical		resulting in death)	Due to (or as a consequ	ue de of):							
ä	Examiner		Sequentially list conditions,	b								
	p #	iner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect	uence of					- 61		
5	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ								
60,	be ex			Due to (or as a consequ	uence or).							
68760,	ertificate be executed ing physician and e as the burial-transit	Medical		d								
$\times$	certificate be executed iding physician and ise as the burial-transit		IF FEMALE:	23c. If yes, outcome pf pregna	incy				23d Da	te of delive		
80	attending	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	Ectopic pregnanc Other (specify) _	У				-	'ear
o.	that the de led by the a detached i	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown		,,,,,						
Δ.	requires that the death een signed by the atter rould be detached for u	y P	Part II. Other significant conditions co	entributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of de	eath?
rds	quires n sign	d by						1 □ Y	es 2 No	3 ☐ Proba	ably 4 □U	nknown
Division or Vital Records,	≥ 0 5	Completed						24a. Was a	n 24b.	Were autop	sy findings a	ıvailable
Ä	о <u>г</u> о	m o						autops perfor	med?	death?	ipletion of ca 2	use of
ital		Be C	25. Was case referred to medical				26. Place of De	ath (Check only on		1 162	2   140	
<b>Z</b>	ys dir S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth	ner: 4 Nursing I	Home 5 Reside	ence 6 □Oth	er (Specify	)	
0 L	ding Ph h. After thi funeral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe ho	ow injury occur	red		
ioi	Attending r death. ector: After	atio	1 Natural 5 □ Pending investigation	(	,,		Yes 2 No					
<u>Vis</u>	r Atte er de recte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (S: City or Town	treet and Numb n, State)	er or Rura	Route Numb	ber,
	ital or rs aft ral DI led in	Cer										
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		sician: To the best of my kno liner: On the basis of examina and parager stated.								)
	Fo th within Fo th	Me	29b. Signature and title of certifier	201		29c. Licens	se number	2	9d. Date signe	d (Month, I	Day, Year)	
	1-0		The court	OF enta	us	1) 8	21438		NOV	130	100	7
•			30. Name and address of person who co	on oleted cause of death (Item	23a) (Ty <u>pe,</u>	Priot	1-011		٨		14.	
		· I	1n11400 1 101	m ATTA	441	1164 F	NSHA	16HWA	1 MNN	APOUL	(Inn?	4140
_	24		1111111111 Vi Cal	6 00 111 111	1 1 3	1000	30.	( 4 ( ) 00 . (		111 0	<u>, , , , , , , , , , , , , , , , , , , </u>	
	24 Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 5 200	7 Registrar's Signa	ture		30			7 14 0	<i>y</i>	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** :27 M Taphael 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Johns Hopkins Baltimure HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Director 218-60-4915 52 July 13, 1955 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a ~ nother traumatic event, the Marked. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 347 Ballou Court 21231 USA Funeral 11 Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: ģ Specify: black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk. unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk ၉ Ruby Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state Director 21. Signature of Fineral Servic Licensee Konald S. Wade 22. Name and Address of Facility State Anatom Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Jowel days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sawel Examine The law requires that the death certificate be executed burlal-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 > No page 2 s autopsy perform 1 Yes 2 2₩ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To 1 ☐ Yes 2 No 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the reception:
within 24 hours after death.

To the Funeral Director: Af 2

Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 06, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pital, 600 North Wolfa Street, Ballimore Hopkins 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29a. Certifier (Check only one)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes of T

			1 - For State Registrar	State of Mai	Cei	tificate of I	Death	rentai Hygi	ene 2007	36565
٥	Physici	an	Decedent's Name (First, Middle, Last,     To Classification of the Color of th					2. Date of Death Month	Day Year	3. Time of Death 3:40 AM M
js.	/Medio		Richard Lee Cheno  4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	October	4c. County of Deat	
	Exami	Ci	Dove House				ninster		Carro1	
	Funeral Director		220-34-7332	x 7. Age	(In yrs. last birthday) 58 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept 9,	Year) 9. Birt 1949 Ma:	hplace (State or Foreign nuntry) ryland
	ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	a-f eh	ctor	MD Carrol1		Westmi	nster				1 ☐ Yes 21 No
	th with the 23e or 28	Funeral Director	10e. Street and Number 30 Locust Street	#408		10f. Zip Code	21157	10	g. Citizen of What Co USA	ountry?
JU36	be filed within 72 hours after death with the Maryland at Hygiene. And thypiene. And other then "natural", or Items 23s or 28s-f show event. Its Madical Esaninar must be untilised at	þ	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2√2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: wh	e, etc.
1215-0036	within 72 h ane. then "natu	Completed	15. Decedent's Edu (Specify only highest grad	le completed)  College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of works	ing 1	6b. Kind of Business/	Industry unk
7 0	Hygie other		10 17. Father's Name (First, Middle, Last)	0		tree tri	mmer 18. Mother's Name	e (First, Middle, M	laiden Sumame)	
yland	uld be Vental irked o	To Be	Robert Lee Cheno	with			Ruby Je	ean Morr:	is	
Mary	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Ty				and Number or Rura	al Route Number,	City or Town, State, 2	
ຍ ອົ	s 1 and 2 should of Health and Mer Item 27 is marke other traumatic		Charlotte Harmon/ 20a. Method of Disposition	friend	906 ( 20b. Place of Dispo				inster, MD	
baitimor	permit. Pages Depertment of I Important: If Its any Injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other. (Specify)	1	cemetery, cren	natory or other plac	e)			
e D	Depermine Depermine Important Irreportant		21. Signature of Funda Senio Dicensi Nona III	1/ale	Ba	ltimore.	MD 2120	1	Baltimore	Street
F	Physician /Medical Examiner		23a. Part I. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a.	consequence di):	er the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
,0070	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician end ral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	s	consequence of):					
.O. DOX	w requires that the death certific been signed by the attending p should be detached for use as is	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	☐Fetal death 3☐	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ords, r	equires that en signed b	፩	Part II. Other significant conditions cor	ntributing to death but	not resulting in the ur	nderlying cause give	en in Part I.	2.5	acco use contribute to	the cause of death?
	: The law re cate has be , page 2 sho	Completed						24a. Was an autopsy perform	ed? / death?	utopsy findings available completion of cause of
	sician certifi rector	Be	25. Was case referred to medical examiner?	fospital:		Othe		h (Check only one		Davelle
5	g et e	ation; To	1 Yes 2 No '  27 Manne of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	4   Nursing no	me 5 Resider 28d. Describe hov		city) DOVE-NOUSE
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral o	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ural Route Number,
	he Hospit in 24 hour he Funera pletely filli	edicai	29a. Cert fier 1 Certifying Phys	sician: To the best of ner: On the basis of e and manner state	xamination and/or inv	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To t To t	∑	29b. Signature and title of certified	W	Ms	29c. License	number 393		d. Date signed (Mont	
			30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,	Print)	Westylins	SM MIN	31157	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	41	1	1112	41-	

			For State Registrar	State of Ma	ıryland		artment r <i>tificate</i>					Reg. No	A A A	7	365	
	Physici /Medic	al	1. Decedent's Name (First, Middle, La.  7U \( \) i \( \) i \( \) i \( \)  4a. Facility Name (If not institution, give				4b. City, T		ROL ocation of	L	2. Date of De Month	Da Da		Year 2007 f Death	3. Time of D	
	Examir Funeral Director	er	7HE TO HWS HOP 5. Social Security Number 212-50-2331	CINS HOS	0/74 e (In yrs. las 56		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs.	8. Date of Bi (Month, Di Nov 18	av. Year)		9. Birthpla Count [ary]		Foreign
	Maryland a-f show ffied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD			Town or Lo								10	d. Inside City	
	ath with the 23a or 28a ust be not	ral Director	10e. Street and Number 2829 Montebello				10f. Zip (	21	214				US	A		
5-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or flems 23a or 28a-f show ant, the Medical Examiner must be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🖾 Divorced	12. Was Decedent & Armed Forces?  1   Yes 2   M h If Yes, Give Year or Dates:			1 □ Yes 2	No No	Specify:	gin? (Spe , Puerto F	cify Yes or Na Rican, etc.)		Specify:	white, e	te.	
21215-(	d within 72 h giene. <b>er than "nat</b> u <b>, the Medical</b>	Completed	15. Decedent's E. (Specify only highest gr. Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5 2	+)	(Give life.	dent's Usual kind of work DO NOT use lminis	done du retired) trat	iring most or			he	ind of Bus	care	ustry	
Maryland 2121	ould be file   Mental Hy   larked othe  atic event,	To Be C	17. Father's Name (First, Middle, Last  Jerome Edward N	Nejedlik		401 14 11			Mar	ie Li	(First, Middle illian I Route Numi	Bron	nwell		Codel	
altimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship ( Laura Carroll/dau  20a. Method of Disposition  1 Burial 2 Cremation 3	nghter  Removal from State	20b. Pla	1818		For	ty La	ane I	Hampste ate	ead,		1074		
Baltin	permit. Pa Departmer Important any Injury once,		4 Donation 5 Other (Special 21. Sign ture   Funeral Supplements   Funera	and the second	ector	-	2 Name and tate A altimo		-	bard 2120	655 W 1	. Ba	1timo	re S	treet	
	Physician /Medical	-	23a. Part1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	ne. POX 1.	4	ter the mode	of dying	, such as	cardiac o	r respiratory	arrest,		13	Approximate Interval Betw Onset and D	veen Death
· o	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	b. ASP Due to (or as  c. UPP Due to (or as	IRA a conseque a conseque	TION online of):		NT	ESTI	WA	IL BC	LEE	D		1 Hou 5 Hou, 2 mos	RS RS
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ▼ No 9 □ Unknown	d. EWG	pf pregnan 2 🗆 Fetal (	icy death 3[	□Ectopic pre	gnancy	201	SE	ASE		23d. Date Mon	e of delive	ry	ear
Ω.	luires that the signed by the detaction	by	Part II. Other significant conditions	contributing to death b	ut not resul	ting in the u	ınderlying ca	use give	n in Part 1.						e cause of de	
al Records,		Completed		1.5					00 8		1 Yes	topsy rformed? 2 \Begin{array}{c} N	p	nor to cor eath?	psy findings a npletion of ca 2 <b>X</b> No	available ause of
Division or Vital	ilng Phys After this uneral di	Certification: To Be	25. Was case referred to medical examiner?  1 Ty Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined.	28e. Place of inj	y Year)	28b. Time of Injury	M	3c. Injury Work 1 🔲 Y	r: 4□ Nu	ursing Ho		sidence e how inji	ury occurre	ed	/) I Route Num	ber,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	edical	29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examinati	/ledg <i>e</i> , dea on and/or ii	th occurred a	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to th	ne cause( le, date a	s) and mai nd place, a	nner as s and due to	tated. o the cause(s	;)
)	To the within 2 To the complet	M	29b. Signature and title of certifier	MEDICA	se do	crur	290.	RES	number	0		29d. D	ate signed	(Month,	Day, Year)	7
	St Regist	ate rar	30. Name and address of person who BRUCE SABATH 31. Date filed (Month, Day, Year)  NOV 1 5 20	7HE JOH	eath (Item NS H ar's Signat	23a) (Type	Print) S HOSP	ITAL	, 600	No	RTHWO	LFE	STRUE	T, 8.41	TIMBE M	MAKYU

NOV 1 5 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 **Physician** MEREDITH BRYAN CAMPBEL 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL 9. Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, **Funeral** Days Hours Min. (Qu 29-50-8181 6 03/21 6 Director Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. The marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Directo SILVER SPRING MONTGOMERY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number SA 20910 CARROLL SHELTER HOUSE Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced WHITE 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COOK RESTAURANT UNK NNN 1 11% 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk permit. Pages 1 and 2 should be fi Department of Health and Mental I Important: If them 27 Is marked otl any injury or other traumatic even once. Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SPRING MD 20910 FOREST GLEN RD SILVER HOLY CROSS HOSPITAL 1200 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Sign ture of Eureral Service licensee A. Director 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CARDIO PULMONARY /Medical Due to (or as a consequence of) Examiner SEPSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner VISCOUS NON TRAUMATIC PERFORATED Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 WUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 2 Be Medical Certification: To 2

law requires that the death certificate be executed for use as the burial-tran and Division or Vital Records, P.O. Box 68760, attending physician ed by the a been signed b should be deta page 2 The certificate or Attending Physician: After this certification funeral director, this

Baltimore, Maryland 21215-0036

after death.

I Director: /
d in by the f Jhc. In 24 hours Se Funeral Disc.

			1 Yes 2 No 1 Yes 2 No						
5. Was case referred to medical	26. Place of Death Check onl one								
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing H	dome 5 ☐ Residence 6 ☐ Other (Specify)						
7. Manner of Death 1 Matural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be determined		et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Pga. Certifier (Check only one)  1 ★ Certifying P 2 ★ Medical Example 1	hysician: To the best of my knowledge, death miner: On the basis of examination and/or invalent and manyer stated.	occurred at the time, date and placestigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)						
Oh Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)						

address of person who completed cause of death (Item 23a) (Type, Print)

LEMMA

SPRING MD FOREST GLEN RD SILVER

200

State Registrar 31. Date filed (Month, Day, Year) NOV15 2007

SIRAK

29b. Signature and title of certifier

am 1200 32. Registrar's Signature

within 24

٥

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4a. Facility Name (If not institution, give street and number) hereso 2007 NIOV orak /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkville Avenue al timore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 K F Yrs. 9 186-01-0398 Director 12/09/1915 Plymouth, PA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 ☐ Yes 2 No Director Saltimore arkuille 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? "natural", or items 23a or dical Examiner must be 2123 Funeral venue 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3 ₩idowed 4 Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. 2 Stewart Department of Health and Mental Hyg important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be stephen  $\mathcal{M}_1$ KO ၉ eronica Divorchak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorak Bourbon Court Perry Itall Konald Md 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ial 11/16/2007 Baltimore Md 4 Donation 5 D Other (Specify) Cemetery Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel + Cremation Str-Parkuille 8800 Harford Road Parkuille md 21234 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ( E) ( EMCUNCI **Physician** Ciu do /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to initiodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pursecularios of Examiner Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph I for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2∏ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 1 ☐ Yes 1∐ Yes 2 410 2□ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Hospital or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 [🖵 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7505 Osier Drive Suite 212 Towson Md 21204 Francis X armod

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 5 2007

. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 11, 2007 **Physician** 2:19a M Gertrude L. Daniels /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Villa Nursing Home Catonsville Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 92 yrs. 8. Date of Birth (Month, Day, Year) Social Security Numbe **Funeral** Days Hours 1 ☐ M 2 🔀 F 577-18-7217 3. 1915 Washington\_DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 XNo Baltimore MD Arbutus Director 10e. Street and Number 22 E. Deer Run Court 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with the Hygiene. Wher than "naturat", or items 23a or 3 21227 United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. White ò 3 X Widowed 4 ☐ Divorced ed other than "natural"; event, the Medical Exa Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Supervisor</u> Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: if Item 27 is marked other any Injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Davis Inez Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Malone - Daughter 22 E. Deer Run Court, Baltimore, MD 21227 20b. Place of Disposition (Name of Meadowridge Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11-14-2007 | Elkridge, MD 4 □ Donation 5 □ Qther (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vakula1 1221 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for seils consequents of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 DEctopic pregnancy Day in the past 12 months? 1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown 9∏Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy 1□ Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check onl one Be Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of 28c. Injury at Work? After Injury 1 Natural 5 Pending investigation ours after death. neral Director: A' y filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

6

DHMH 17 Rev 1/2001

within 24 hours at To the Funeral Completely filled it To the Hospitai

29a. Certifier

(Check only one)

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

2007

and manner stated.

32. Registrar's Signature

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Yelwa houn, 700 mosselin Chaire lane Belf wir 7/128

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** illiam 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number, Examiner Baltimore Hosp:ta If Under 24 Hrs. 8. Date of Birth (Month, Day, 10-27-7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M M 2 □ F 60 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 Yes 2 □ No Be Completed by Funeral Director Kaltimore 10f. Zip Code 10g. Citizen of What Country? 21225 nham 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working the DO NOT use retired) d 2 should be filed within 72 in and Mental Hygiene.
7 Is marked other than "n ordary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle 2 19a. Informant's Name/Relationship (Type. Prin Address (Street and Number or Rural Route Number, City Health Item 27 i λωK∶ns North 20a. Method of Disposition 20b. Place of Disposition gemetery, cremator Department of Important: If Its any injury or o once, 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other ( 3 ☐ Removal from State 5 ☐ Other (Specify) Funeral 21. Signatu Approximate
Interval Between
Onset and Death ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Immediate Cause (Final **Physician** ancer UMdisease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-tran Due to (or as a consequence of): attending physician for use as the burial Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9□Unknown 9 Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide ō within 24 hours at To the Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BCKO VON MD KI.

Registrar

State

31. Date filed (Month, Day, Year)

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend #5	Per INF (	3873 11	736/Depa 736/OPer	irtment of H Jb <i>tificate of I</i>	lealth and N Death	lental Hy	giene Reg. N. 20	07	36571	
1 9	a a		Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time of Death			1	
	Physicia /Medic		1-015 NOVEREY ANDERSON										
								4c. Count	y of Death				
	- 15. Lan Statement	00	JOHNS HOPKINS BAYU		ICAL CE	NEL	If Under 1 Year	If Under 24 Hrs.	9 Date of Bir	th	Q Birthola	ace (State or Foreign	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	96	. <i>last birthday)</i> Yrs.	Months Days	Hours Min.	Nov 22	y, Year) 1910	Countr	York	
	Director		220-32-7 <del>818</del> Usual Residence of Decedent		90				1107 22	, 1510	2.0		
yland	at		10a. State 10b. County		10c. C	ity, Town or Lo	cation				10	d. Inside City Limits	
<b>BAITIMORE,</b> IMARYIANG Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	a-f sh lified	ctor	MD Kent Chestertown									1 □Yes 2√∏No	
	or 28 e no	Director	10e. Street and Number				10f. Zip Code		10g. Citizen of		y?		
	23a rust b	ra l	305 Heron Poin		1 ☐ Yes 2 No If Yes, Give Year or Dates:		2162		seif ( Vec or No		USA  14. Race - American Indian,		
	or items miner m	y Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marr	ied Armed F 1 ☐ Yes If Yes, 0			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2🏹 No	Rican, etc.)	Bla	Black, White, etc.  Specify: white  Kind of Business/Industry			
5-0036 72 hours af	tural", al Exa	ed by	3 Widowed 4 □ Divorced				edent's Usual Occupation					16b. Kind of E	
in 72	" na'	Completed	(Specify only highest grade completed)			(Give	(Give kind of work done during most of work life. DO NOT use retired)						
with A	jene. r thar the N	E	Elementary/Secondary (0-12) College (1-4or 5+)				housewife			own home			
and de filed and led be filed and led be filed control by ced other cevent, it	al Hyg	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nam		, Maiden Surna	ıme)		
Vial Ments Ments arked		2	Walter Joseph					Lois Ma					
lar 2 sh	ls m		19a. Informant's Name/Relations				•	and Number or Ru					
6, 5 1 and	Health		Harry J. Duffe	ey III/so		Place of Dispo	sition (Name of		Park Roa	id Centr 20c. Location		e, MD 21617 vn, State	
Pages	nent of l int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (S			cemetery, cre	matory or other pla	ce)					
bartimor permit. Pages	Departn Importa any inju once.		21. Sign ture of Euneral Service	S Wave	Wilesto			ess of Facility Comy Board		. Balti	more S	treet	
20			23a. Part . Enter the disease, of shock or heart failure. List	complications tha	t caused the de		altimore, terthe mode of dyi			ırrest,		Approximate Interval Between	
Ph	ysician		Immediate use (Final disease or co-dition	Sub	Subdu ( Henston 9				Onset and De				
/Medica			resulting in death)	Due t	o (or as a cons	equence of):	0	0.1	01	1		100	
Ex	caminer	I. I	Sequentially list conditions.	b		Manta	n d	susdy	21 En	400 ng.			
Sit Sit		ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due t	o (or as a cons	equence or):							
, xecul	physician and the burial-transit	Examine	that initiated events resulting in death) Last	c	c			Down MY MEDICAL EXAMINER					
876U ate be e	siciar buri	dical E							Daw	- m)	46	MINER	
Tificat	g phy as the	ledio							NO.	ON APPROVED E	WEDICAL E	XXXIII	
cords, F.O. BOX 68/60, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Liv	outcome pf preg e birth 2  Fe egnant at time o known	etal death 3	⊒Ectopic pregnanc ☐ Other (specify) _	у	CERTIFICATI			ry Day Year		
	signed by be detac	b		ons contributing to	contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
or o		eted				<del></del>			24a. Was	-   24k	Wore autor	osy findings available	
VITAL RECORD sician: The law require	ate has page 2	Completed				· · · · · · · · · · · · · · · · · · ·			auto		prior to con death?	npletion of cause of	
Or VITA Physician:	this certific	Be	25. Was case referred to medica examiner?				Ott	26. Place of Dea	ath (Check only	one)			
<u> </u>	.5 ₽	은	1 Nes 2 No 27. Manner of Death		Inpatient 2 te of Injury	☐ ER/Outpatie	III. OLI DOA		lome 5 Res	idence 6 C		)	
ding	h. After thi funeral o	ion	1 □ Natural 5 □ Pendir	/8.8	onth, Day Year		Wo	ork? ]Yes 2∐No	l .	ct fell			
<b>DIVISION</b> I or Attending	deat ctor:	fica	3 Suicide 6 Could	not be 28e. Pla	ace of injury - At	home, farm, st	reet, factory, office				mber or Rura	Route Number, Cermpn's Druc,	
	s after al Dire	Certification:	4 ☐ Homicide determ	bu	ilding, etc. (Spe		nome		Chester	two, N	1D East	Cermpos Di ac,	
e Hospit	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner: On the	the best of my less basis of exam anner stated.	nowledgd, dea ination and/or i	th occurred at the t nvestigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and e, date and plac	manner as st e, and due to	ated. the cause(s)	
To th	within <b>To th</b> comp	Me	29b. Signature and title of pertific	di			29c. Licen		<b>(</b>	29d. Date sign			
)			1				17/	=5-00	U		610	J	
			30. Name and address of person	who completed can who completed can who completed can be seen as a	ause of death (II	tem 23a) (Type	Print) Sten Du	e Ba Hn	Mesm	0212	24		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year, NOV 1 5 2	007	. Registrar's Sig	gnature	sk)	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30.perDVR.0873, 11/15/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 Leroy Day /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Hyattsville Under 1 Year | If Under Heartland of Hyattsville Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 ₹ M 2 🗆 F 75 Dec 31, 1931 Washington DC Director 578-42-2206 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2855 Bladensburg Road #40 USA 14. Race - American Indian, Black, White, etc. 20018 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 Specify. Specify: black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction 1aborer unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fill Health and Mental H tem 27 is marked oth Be Eugenia Mae Terrell Augustus Asbury Day ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2855 Bladensburg Road NE #4 Washington, DC 20018 permit. Pages 1 an.
Department of Healt,
Important: If Item 27
any Injury or other tra Lillian Day/sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5-XOther (Specify) in state 21. Signatur of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) proumone Physician /Medical Due to (or as a consequence of): Examiner lassivo if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical ası IF FEMALE: for use a 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate has Sophoyea 10 2 7 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, 8 Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes Certification: To After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō [Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, Hospital

> State Registrar

31. Date filed (Month, Day, Year)

NOV 1 5 2007

29b. Signature and title of geriffier

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24

2 2

47867

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Vear **Physician** JAMES NOVEMBER 2007 12:40 A ROBERT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bel Air Under 1 Year | If Under 24 Hrs. Upper Chesapeake Medical Center Harford 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours M 2□ F 29,1947 Maryland Director 60 216-44-0044 Sept. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If tiem 27 is marked other than "ratural", or items 23a or 28a-f show any inJury or other traumatic event, the Medical Examiner must be notified at any inJury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21001 1 East Inca St. Maryland 21215-0036 194 Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 → Yes 2 → No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 █XNo Specify: Specify: White þ 3 Widowed 4 XDivorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Repair 12 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAM James Corbett Dunn Lonis Love Hankla ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 616 Longwood Court, Edgewood, Maryland 21040
e of Disposition (Name of Date 20c. Location - City or Town, State Robin Susan Gaston/ Sister ŽZ Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Incremation 3 ☐ Removal from State Hilltop Service Corp. 11-16-07 Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility
MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

The caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 23a. Part1. Enter the disease, or complications, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 19 Tion (00 **Physician** /Medical Due to (or as a consequence of): Examiner Ran (QVO schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) 13/07 00  $\pm 0$   $\Omega$  Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Vunknown Were autopsy findings available prior to completion of cause of ovasau (an 24a. Was an certificate has autopsy performe ouges tive 2 No 2 MNo 1 ☐ Yes 1∏ Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☑ Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie tending Myscian 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UCHE UPPER CHESAPEAKE DR BEL AIR, MD 21014 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Antoinette Mary E		I- For State	Stat	e of Maryla		epartmei <i>Certificat</i>		Health and Death	Menta	al Hyg		eg. No.	200	7 36	57
Physicia	n/	Registrar 1. Decedent's Name	e (First, Middle,L	.ast)						-	Date of Deat	h Dav	Year	3. Time of Death	
Medical Examin			IETTE MA				<del></del>	b. City, Town, or L	eastion of		November	11, 20	07 County of Deat	1310 hrs	
0		4a. Facility Name (i 8657 Black		give street and nu	imber)		"	Parkville	ocation of	Death			Itimore Co		
Funeral		5. Social Security N		Sex	7. Age (In	yrs. last birtho	ay)	If Under 1 Year	If Under	_	3. Date of Bir	th(MM/DE	D/YYYY) g. Bi	rthplace (State or	<u></u>
Director		217-12-3	3892 1	M_2\_XF		85	Yrs.	Months Days	Hours	Min.	2/14/	1922	C	gn MARYLAN puntry)	ID
'n		Usual Residence of			140	c. City, Town or	Logatio							10d. Inside City I	Limits
ow any		10a. State MD	10b. County B <b>ALTI</b>	MORE	100			ILLE						1 Yes 2	1
ryland a-f sh	뱒	10e. Street and Nu					turv.	10f. Zip Code		<del>-</del>	1	0g. Citize	n of What Cou	intry?	
the Ma 1 or 28	Director	8657 BLA	ACK OAK	ROAD				21234				US	Α		İ
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatie event, the Medical Examiner must be notified at once.		11. Marital Status		12. Was Dec		er in U.S.		s Decedent of Hisp es, specify Cuban,						rican Indian, Black	
death or iter	Funeral	1 Never Marri		1 Yes	2 X	No				derto rui	carr, etc.,				
rs after rral",	2	3 Widowed  15. Decedent's Ed		or Dates:		ated) 16a De		Yes 2 No		nd of wor	k done		pecify: WH.	ITE /Industry	
2 hour	Completed	Elementary/Sec			1-4 or 5+)	du	iring mo	ost of working life.						•	
5-0036 iled within 7 Hygiene. I other than	Jdu	8TH GRAI	Œ			H	OME	MAKER				OW	N HOME		
15-0 illed w Hygie d othe		17. Father's Name		ast)				1		,	irst, Middle,		urname)		
2121 wild be fi Mental I marked	To Be	JOSEPH 19a. Informant's Na		(Tyne Print)		19b.	Mailing	Address (Street			A HICK		or Town, Sta	e, Zip Code)	
MD 2 d 2 shou lith and P m 27 is r		SHARON F				- 19		A HALLM						_	
e, Nand I and Health		20a. Method of Dis	position			20b. Place of	Dispos	ition (Name of cem ner place)			Date			r Town, State	
altimore, mit. Pages I ar spartment of Hee prortant: If iter jury or other tr		1 X Burial 2	Cremation Other Spec		rom State	PARKWO	OD	CEMETERY		11/1	6/2007	BA	LTIMOR	E, MD	
alti rmit. epartm aports jury o		21. Signature of Fu	ineral Service Li	censee	0	N		ame and Address						HOME, P.	Α.
		# ROTA 23a. Part I. Enter to	- Hai	1 - pav	/ Of	death Do not		21 LOCH I						21286 Approximate In	nterval
Physician —		failure. List or	nly one cause of	each line.			eriter ti	ic mode of dying,	30011 23 00	. 4.40	oophator, a	001, 01100		Between Onse Death	
⊤xaminer		Immediate Cause or condition resulti		a. Head and Due to (or as			_								
	L	Sequentially list co		b Due to (or as											
	nine	if any, leading to in cause Finer Und (Disease or injury	arlying Cause	c.	a consequ	ience or):								-15	
ted 1 1 1 1 1 1 1 1	Examiner	events resulting in		Due to (or as	a consequ	ience of):									
O, e be executed /sician and burial - transit	edical	UNPENDED	)	AMENDED											
760, cate by physic the bur	/Mec	IF FEMALE: 23b. Was decedent	t preapant in the			of pregnancy							Date of delive	-	
Box 68760 e death certificate I the attending phys	cian	past 12 month		1 Live		ne of death 5		tal death 3 [ her (Specify)	Ectopic	pregnand	СУ	ļ, '	Month	Day Ye	ai .
BOX e death the atte	Physician/M	1 Yes 2 ✔		9 Oliki											
ires that the signed by it be detach	by P	Part II. Other sign	ificant conditio	ns contributing	to death b	ut not resulting	in the u	underlying cause g	iven in Par	t I.				to the cause of dea obably 4 Unk	
S, Fluires apprinted and be-								<del></del> -			1 24a. Was			autopsy findings av	
cords, law requir has been s	Completed										auto perf	psy ormed?		completion of cau	
tal Rection: The certificate	Cou	75 144		<del></del>				26 Place	of Death (	Chark ar	1 Yes	2 No	1 🗸	Yes 2	No
Division of Vital Records, P. rall or Altending Physician: The law requires the rafter reath.  all Director: After this certificate has been signed in by the funeral director, page 2 should be do	Be	25. Was case refe examiner?		Hospital:	Inpatient	2 ER/Ou	tpatient		Other;		Home 5	Resider	nce 6 🗸 Ott	ner: Scene	
of Vil ing Physic After this	.: To	1 ✓ Yes 27. Manner of Dea	2 No	28a. Date	e of Injury	28b. T	ime of I	Injury 28c. Injur	y at Work		8d. Describe		ry occurred		
ion tendir eath. tor: A	ation	1 Natural 2 Accident	5 Pendir	19   Nav. 44	th, Day,Year D: , 2007	7 FOUI		1_Y	res 2 🗸	No					
ivis or Al Birec Olin by	Certification:	3 Suicide	6 Could	not be 28e. Pla			m, stre	et, factory, office b	uilding, etc	- 1	or Town.	State)		Rural Route Numbe	er, City
Dospital hours uneral y fille		4 Homicide	detern	1-5		house		rred at the time, da	to and als				d, Parkville,		
Livision of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after eath. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only one) 2	Certifying Phy Medical Exam	iner:On the basis	of examin	nowledge, dea nation and/or in	vestiga	tion, in my opinion	, death oc	curred at	the time, date	e and plac	ce, and due to	the cause(s)	
To vit	Me	29b. Signature an	d title of certifier	and manner	stated.			29c. Licens	e number			29d. E	Date signed (/	fonth, Day, Year)	
		( a	rele.	Hal	la	n		O.C.1	M.E.			Nov	ember 12,	2007	
79		30. Name and add					2	Otropt Dalti-	ore MD	24204					
4	0 10	Carol Allan 31. Date filed (Mon	<u> </u>	istant Medica		ner 111 i Signature	enn	Street, Baltime	ore, MD	21201					
Si Regis	tate trar		NOV 1	2007	Real	· H	1	south!							
DHMH 17 Rev 1/2	2001	<u> </u>		DOME		OR	GINA	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 365 1- State Registrar Amend #10b, perFH, 6873, 11/15/07 TT Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day 1:44 a M **GFORGE** EGE CARROLL **Physician** 14, 2007 Nov. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** Hours Year) Months 10, 1928 Maryland 84 214-18-3083 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a, State natural", or items 23a or 28a-f show dical Examiner must be notified at Anne Arundel 1 Yes 2 No Brook1vn N/A Maryland 10f. Zip Code 21225 10g. Citizen of What Country? 10e. Street and Number U.S.A. 5318 Wasena Avenue Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mential Hyglene. Important: If Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Branch Motors 8 0 Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Morris Ada George Ege ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5318 Wasena Avenue, Brooklyn , Maryland 21225 (Wife) Ege Roxie 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 11-15-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund Pervice Licenses Name and Address of Facility 237 Fer Patapscop Avenue, Baltimore McCully-Polyniak Funeral Home P.A. Maryland 21225 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. ock, or heart failure. List only one cau nediate Cause (Final OBSTVI war **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner sician and Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Completed by Physician/Medical attending f IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the the 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 2 No 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 3□ DOA 1 Yes 10 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient s after death.

I Director: After this o Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral C I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 17 Rev 1/2001

State Registrar

ature and title of confifier

31. Date filed (Mont)

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month 4:11 A M NOV. 11, 2007 CAROLE LEE EUBANK 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL BALTIMORE-WASHINGTON MEDICAL CENTER GLEN BURNIE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number 1 □ M 2 1 F SEPT. 20, 1937 MARYLAND 70 219-34-0093 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No ANNE ARUNDEL GLEN BURNIE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21060 6703 RAPID WATER WAY #103 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify: 3 ☐ Widowed 4 ☑ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 U.S. GOVERNMENT ADMINISTRATIVE SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUTH ROSALIE SLINGERLAND CHARLES LEROY PHILLIPS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) CATONSVILLE, MD 620 MEYERS DR. ROBERT EUBANK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 16 1 M Burial 2 □ Cremation 3 □ Removal from State 2007 5 Other (Specify IVY HILL CEMETERY LAUREL, MARYLAND 4 Donation 21. Sign 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. SE; GLEN BURNIE, MD 21061 23a. Parts Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCUEROTIC CARDIOVASCULAL DISEASE YEARS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SQUAMEUS CELL CANCER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1⊟ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident

**Examiner** burial-trar Records, P.O. Box 68760, physician for use **Division or Vital** After

**Physician** 

Examiner

Funeral

Director

28a-f show

Directo

Funeral

þ

Completed

Be

ပ

Examiner

Physician/Medical

Be Completed

Medical Certification: To

3 ☐ Suicide

29a. Certifier

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medi-A Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medic 1 Examiner must be n once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

/Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

D31136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KILBRIDE RD BALTIMORE, MID 21236 9005 (in) 32. Registrar's Signature

31. Date filed (Month, Day, Year)



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Nertificate of Death		2007	36578
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  Dorothy F. Elliott		2. Date of Death Month		3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  Keswick Multicare Center	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 217–12–0003 1 M SEF 90 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry) Land
	Maryland a-f show	tor	Maryland N/A 10c. City, Town or Baltim	Location			10d. Inside City Limits 11 Yes 2 □ No
	ith with the 23a or 28i	Funeral Director	10e. Street and Number 700 W. 40th Street	10f. Zip Code 21211	10g	. Citizen of What Cou USA	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a McJical Examinat must be notified at once.	by Fune	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes XX No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ameri Black, White, SMhite	
Maryland 21215-0036	within 72 huiene. than "natu	Completed by	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired) Assembly Worker	king	Sb. Kind of Business/In	
land 2	uld be filed Mental Hygi riked other itlc evant, I	To Be Co	17. Father's Name (First, Middle, Last) Walter Talbott	18. Mother's Nam	ne (First, Middle, Ma ry Stahlin	aiden Surname)	ianei
	and 2 sho ealth and h n 27 is ma		1	ailing Address (Street and Number or Run 338 Roland Avenue #		,	,
Baltimore,	Pages 1 tment of H tant: If ital		1∰ urial 2 □ Cremation 3 □ Removal from State 1 □ Donarion 5 □ Other (Specify)	rematory or other place) idge Cemetery 11/1	6/2007 Pi		Maryland
Ba	Depar Depar Impor any in		21. Signalus of Funeral Service Licensee	22 Name and Address of Facility Burgee—Henss—Seitz 3631 Falls Road, B	Baltimore.	Marvland	
	Physician /Medical		23a. Part1. Eyler the disease, or complications that caused the death. Do not shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	, demension	or respiratory arrest	t.	Approximate Interval Between Onset and Death
	Examiner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ular disease			Years
8760,4	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C				
.O. Box 6	at the death certific by the attending partiached for use as	Physician/Me		3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?
		Completed			24a. Was an autopsy performe	prior to co	psy findings available mptetion of cause of
Vital	ystclan: is certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		th (Check only one)	ce 6 Other (Special	
DIVISION OF	r Attending Phy er death. rector: Atter thi i by the funeral o		27. Manne of Death  1  Natural 5  Pending (Month, Day Year)  2  Accident investigation	of 28c. Injury at	28d. Describe how		<i>y</i> )
DIVIS	ital or Atterns after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town, S		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	e and place, and due to	o the cause(s)
	5 with		Dr. Isabelle Var Gregor 70	29c. License number D / 3 6 5 7		I. Date signed (Month,	
_	7		30. Name and address of person who completed cause of death (Item 23a) (Type TIBASELIE THEGREGIEM, 700 W. 4	OK STREET, BAL	TIMORE,	070 2121	/
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 5 2007	Le Company de la			

1 - Stat 1. Deced

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coutin's - Dump

To Be Completed by Funeral Director

Physician /Medical

Examiner

**Funeral** 

Director

State Registrar	State of Ivial	ryland / Depa <i>Cer</i>	irtment of tificate of		a Men			_
Decedent's Name (First, Middle, Last	t)	Cer	cate 01	Dealli	2. Г	Reg. Date of Death	No. 200	7 3.5579
Daniel	James	Fleck			N		Day Yea	3 2:00 PM
acility Name (If not institution, give			•	or Location of D		T	4c. County of De	
Joseph Ritchie He	-	(In yrs. last birthday)	If Under 1 Yea	Baltimon		Date of Birth		N/A Birthplace (State or Foreign
19-32-8240	X 7. Age	73 Yrs.	Months Days		Min. Oc	Month, Day, Ye	1934	Country) Maryland
Residence of Decedent State 10b. County		10c. City, Town or Loc	ation					10d. Inside City Limits
	timore			utus		_	_	1 Yes 2 No
Street and Number 1255 Brewster St.	reet		10f. Zip Code	21227		10g.	Citizen of What United	Country? States
Marital Status	12. Was Decedent Ev Apped Forces?	ver in U.S. 13. V	L Vas Decedent of f Yes, specify Cu	Hispanic Origin ban, Mexican	? (Specify	Yes or No- n, etc.)		merican Indian, /hite, etc.
□ Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 X Yes 2 ☐ No If Yes, Give Year or Dates:	1052_	Tes, specily Ct		. nod	,	Specify:	White
15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occ kind of work don	upation e during most of	working	7	o. Kind of Busine	· · · · · · · · · · · · · · · · · · ·
ementary/Secondary (0-12)	College (1-4or 5+	.)	kind of work don OO NOT use retii		9	I .	nited S	
12 Father's Name (First, Middle, Last)		l Po	stal Cl		Name (m)	rst, Middle, Maid	ostal Se	ervice
Father's Name ( <i>First, Middle, Last</i> )  James Fleck						ine Mac		
Informant's Name/Relationship (7 Frances I. Flec							ity or Town, State	
Method of Disposition	Domestic	20b. Place of Dispos	sition (Name of	lace)	Date	200	c. Location - City	or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Dopation 5 ☐ Other (Specify		Wester Acres Cremato			-13-2		denton,	
Signature of Funeral Sorthe Licen	TOMA	22	. Name and Add	Iress of Facility		se Fune	ral Homo utus, M	e, Inc.
a. Part1. Enter the disease, or comp	dications that cause	the death. Do not ente					•	Approximate
shock, or heart failure. List only a mediate Cause (Final	one cause on each line	Danes	hr 10	1	Un .	Watack	07 to 1	Interval Between Onset and Death
ease or condition ulting in death)	,a Due to (or as o	consequence of):	uto Ch	r Wi	IVI Y	red at the	IN 10 100	4
	h	,						
quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury	Due to (or as a	consequence of).						20.4
t initiated events	C					to talk a second		
ulting in death) Last	Due to (or as a	consequence of):						
	.d	Production of the second of th						
FEMALE: b. Was decedent pregnant	23c. If yes, outcome p 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)				23d. Date of Month	delivery Day Year
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown				vision in Part I	1	23e. Did tobar	Co use contribut	te to the cause of death?
	ontributing to death be-	t not resulting in the	nderlying cause	Jiven in Parti				,
1 Yes 2 No 9 Unknown	ontributing to death but	t not resulting in the ur	nderlying cause	jiven in Part I.	İ	1 ☐ Yes	2 No 3 ☐	Probably 4 Unknown
1 Yes 2 No 9 Unknown	ontributing to death but	t not resulting in the ur	nderlying cause	jiven in Part I.	-		- 0 h W W -	
1 Yes 2 No 9 Unknown	ontributing to death but	t not resulting in the ur	nderlying cause	jiven in Part I.	_	24a. Was an autopsy performer	24b. Were	e autopsy findings available to completion of cause of th?
1 Yes 2 No 9 Unknown		t not resulting in the ur		26. Place of	_	24a. Was an autopsy performer	24b. Were prior deat	e autopsy findings available r to completion of cause of th?
1 Yes 2 No 9 Unknown  II. Other significant conditions of the cond	Hospital: 1 ☐ Inpatier	nt 2□ ER/Outpatien	nt 3□ DOA C	26. Place of	f Death (CI	24a. Was an autopsy performe 1  Yes 2	24b. Were prior deat 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e autopsy findings available t to completion of cause of th? Yes 2 \sum No
1 Yes 2 No 9 Unknown  II. Other significant conditions of the cond	Hospital: 1 ☐ Inpatier  28a. Date of Injun (Month, Day	nt 2□ ER/Outpatien	nt 3□ DOA C	26. Place of	f Death (Cling Home 28d.	24a. Was an autopsy performe 1 Yes 2 1	24b. Were prior deat 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e autopsy findings available t to completion of cause of the 2 \sum No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trans Medical Certification: To Be Completed by Physician/Medical Examiner

**Physician** /Medical Examiner

> 24 State Registrar

31. Date filed (Month, Day, Year)

NOV 1 5 2007 DHMH 17 Rev 1/2001

29c. License number

400 64267

Linden AV.

29d. Date signed (Month, Day, Year)

Cultimae, Hp. 21201

11-12-07

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 12 2007 11:55 P M Ralph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRIGHTON GARDENS PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07/16/1921 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** 1**X** M 2□ F Director 219-16-6295 86 MD Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe or 8202 MARCIE DRIVE 21208 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must is U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify WHITE Completed by Specify: 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Elementary/Secondary (0-12) 12 College (1-4or 5+) OWNER REAL ESTATE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAX FISHER THERESA GROLLMAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS FISHER / SON 3739 GREENWAY LANE - OWINGS MILLS, MD. 21117 20a. Method of Disposition 20c. Location - City or Town, State BETHMETE I'L'OHTO CONGPLACE 1 Burial 2 Cremation 3 Removal from State 11/14/2007 WOODLAWN, MD 4 ☐ Donation 3 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Lice se-8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Advanced Damo Yyears /Medical Due to (or as a consequence of): Examiner evelormoculor Sequentially list conditions, if any, leading to infine unate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dut to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been sirrector, page 2 should ! overy disease the readons ion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aurenipidemic, Depossion autopsy 2 No 1 TYes 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division or Vital Records,

Hospital or Attending Physiclan: s after dea...

the

within 24 hours at To the Funeral D completely filled i

Drettary Registrar

Medical

(Check only one)

29b. Signature an atitle of certifier

30. Name and address of per

31. Date filed (Month, Day, Year) NOV 15 2007



on who completed cause of death (Item 23a) (Type, Print)



1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D40371

29d. Date signed (Month, Day, Year)

11/13/07

BACHMONE, NO 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year GunthroD Konald 9:06 PM Nov /Medical 12 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Maryland 214-50-5069 Director 60 09/09/1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10h County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 De es 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2913 Dupont Avenue 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Steel Laborer 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Lee Gunthrop Nina Strickland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 2913 Dupont Avenue, Baltimore, Maryland 21215 Rose Marie Franks / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury ( Metro Crematory Inc. 11/15/2007 Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 'n 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on Viause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Perforation Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician a s the burial-1 Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetai death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No should should 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed?

1 Yes 2 No rector, page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours and very Yo the Funeral Director; Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) P21190 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Ame Parker Frosch
31. Date filed (Month, Day, Year)
NOV 1 5 2007

32. Registrar's Signature

22 South Greene Street. Ballimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 1- State Registrar Amend #30, perDVR, g873, 11/15/07 Opertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Leonard H. Greess 4, 3:20 AM M November 2007 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 40539 Port Place Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ₹ M 2 □ F Director 83 070-18-3462 July 10, 1924 New York Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location Item 27 is marked other than "naturel", or Iteme 23a or 28a-1 ehow other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits MD Director St. Mary's 1 ☐ Yes 2√2 No Leonardtown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 40539 Port Place 20650 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes. Give Year or Dates: 143–46 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry unk (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 government administrator permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Importent: if I tem 27 is marked othe eny injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Julius Greess Celia Bergner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Greess/spouse 40539 Port Place Leonardtown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Europeal Service Lick State Anatomy Board 655 W. Baltimore Street Wade, Director un Baltimore, MD 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician CARCINOUS 1.0 /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificete be executed burial-transit Exami the attending physicien end Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ŏ 3 Ectopic pregn in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown ۵ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 1 TYes 2 No 3 Probably 4 Unknown Completed KIDNE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy cartificate performed 2□ No 1 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home Seriesidence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ 110 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Apecify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e Funeral I 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 228m0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen Patrick Cafferty, MD Great Mills, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 5 2007

2. Registrar's Signature

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 **Physician** November Mark T. Hopkins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Bathmore Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Ye 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1⊠M 2□F 47 218-78-0400 Sept 4, 1960 Director Usual Residence of Decedent 10c. City, Town or Location 10h County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notifled at Director N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** I 2001 Fairbank Road 21209 "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) University Of Pittsburgh Elementary/Secondary (0-12) College (1-4or 5+) Chief Information Officer Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marian L. D'Anna George Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kimberly Anne Brodie-Hopkins, Wife 2001 Fairbank Road Baltimore, Maryland 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/07 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metastatic esophageal cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Gastrointestinal pited Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I embolic cerebrovascular accident 1 Yes Completed 24a. Was an autopsy performe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification:

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Month

36583

22:31 M

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Mary land

2007

N/A

USA

Specify:

14. Race - American Indian,

White

Center

Approximate Interval Between Onset and Death

day

months

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

MP, PhD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number RES 000

Sinal Hospital of Baltimore, 2401 W. Beivedere Ave, Baltimur, MD 21245

Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) November 13, 2007

the

State Registrar

Medical

31. Date filed (Month, Day, Year)

Unelsea C. Pinnix, MP, PhD



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 23:48 M Garnet November 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltmore C. t If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sey 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F 236-24-3026 89 Director Sept 30, 1918 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√2 No Director MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3502 Whell House Road 21220 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) driver transporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Audley 0'Dell Elsie Ann Young ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3502 Whell House Road Baltimore, MD David Hively/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Survice Licensee Ronal of Wade, State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ventricular tachycardia **Physician** 10 minutes /Medical Due to (or as a consequence of): Examiner attending properties for use as ed by the a detached t signed t page 2

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this funeral within 24 hours after death To the Funeral Director: by

Sequentially list conditions	b. Sepsis	24 hours
Sequentially list conditions, it any Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of):  Due to (or as a consequence of):	72 hours
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	23d. Date of delivery  Month Day Year
Part II. Other significant condition	, , , , , , , , , , , , , , , , , , ,	d tobacco use contribute to the cause of death? ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown
		topsy prior to completion of cause of formed? death?
25. Was case referred to medical	26. Place of Death (Check only	v one)
examiner? 1 ☐ Yes 2 No	Hospital: 1   Inpatient 2   TER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Re	esidence 6 Gother (Specify)
27. Manner of Death  1XX Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year) Injury Work?  Ition M 1 □ Yes 2 □ No	e how Injury occurred
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 28e. Place of injury - At nome, farm, street, factory, office 28f. Location	n (Street and Number or Rural Route Number, Fown, State)
	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue

8, 2007

Baltmore, MD

State Registrar

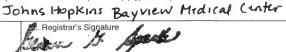
completely

Christine Durand 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NOV 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



C. DURAND

medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 07 **Physician** 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give 4b. City. Town, or Location of Death Examiner Randallstown Baltimore Center Hospital NorthWest 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Se 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 M 2 X 580.03.10Hz 82 Yrs. 11/20/1924 Islands Virgin Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show ns 23a or 28a-f shov must be notified at St. Croix Christiansted 1 XYes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number Welcome Island 00821 state permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23, any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Education Educator 12th grade

17. Father's Name (First, Middle, Last) loyears 18. Mother's Name (First, Middle, Maiden Surname) Be Gondon Abramson elena ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relatjonship (Type. Print) ampfield Road GWUNN Oak MD 21207 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Christiansted, Virgin Island 1 Burial 2 □ Cremation 3 □ Removal from State Christiansted Cemetery 112101 4 Donation 5 Other (Specify) and Address of Facility Vaugh C Greene Funeral Services 21. Signature of Funeral Service Licensee Randalstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart befure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ARD IO HYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ECUISTITUS Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No o 24 hours after death.

Funeral Director: A letely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 and manner stated. 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and title of certific 0066357 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 0, Court Rd. Randall stown MD 21133 5401 VENICATA Registrar's Signature 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

NOV 15

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Charles Jones 5:01 PM Nov /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 6. Sex M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 82 yrs Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 213-20-5385 Director Sept. 19, 1925 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r 28a-f show notified at Maryland Baltimore 1 ☐ Yes 2 No Director Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be 5601 Huntsmoor Rd. 21227 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Engineer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event. the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irven Jones Marie Helen Evans 19a. Informant's Name/Relationship (Type. Print)
Bernice M. Jones, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Huntsmoor Rd. Arbutus, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lakeview Memorial Park 11-12-07 Sykesville, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Ŕd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebellar Infarct CEMPTECHTON NAMORED BY WED AN ELAMINE 36 hours /Medical Due to (or as a consequence of): Examiner Hypotension 30 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending ours after death.

neral Director: #
filled in by the fi 2 Accident 3 Suicide investigation Nov 4 2007 Unk 1 ☐ Yes 2 No Fall with strike to head 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 Home 5601 Huntsmoore Rd, Halethorpe, MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

(Check only one)

29b. Signature and title of certifier

ristin Mount

NOV 1 5 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street.

225 Greene

32. Registrar's Signature

29c. License number

NE 23113

Bautimore

Nov 7, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#20b, perFH, G873, 11/15/07, WS
State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 1- State Registrar Amend #20a-c Per FH G873 11/16/07 In Calle of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 13 **Physician** Van Johnson 0057PM Konald 11 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Windsor Baltimore Greenmeade Koad Mil If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 089.46.3945 1 M 2 ☐ F Days Hours Months Director 08 1953 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Windsor 1 ☐ Yes 2 XNo MD **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Road 21244 3303 Greenmeade 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Hyears Washington Gas Co. Draftsman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ Uh MSon Siona iouna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City) or Town, State, Zip Code) 21244 11/17/2007 Road Windsor Mill 3303 Greenmea Norma JOHNSON 20dWood awn ToMD tate 20a. Method of Disposition Wood James (Name of Long) WBurial 2 Chemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD lenmount Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Cility Jaughn C. Greene Funeral Svcs Randallstown MD 21133 8728 Liberty Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enotic Cerdiovosculos Disease Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) in by the funeral 28b. Time of Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death account of the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23 (Type, Print) 5 2. Registrar's Signature 31. Date filed (Nonth, Day, Year) State 2007 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Northwest Nursing Facility Owings Mills If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1**XX**M 2 ☐ F 64 218-29-3062 Feb. 8, 1943 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Owings Mills MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21117 USA 10090 Owings Mill Run Circle Apt. 312 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**20**No If Yes, Give —— Year or Dates: 1XXNever Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Adrican American Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NCIA 12 youth counselor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Jones မှ 19b Mailing Address (Street and Number or Rural Boute Number, City of Town, State Zip Gode) 10090 Owings Mills, Maryland 19a. Informant's Name/Relationship (Type. Print) Jennifer I. Jones / Sister 21117 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2007 Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician ar e as the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical led by the attending produced detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 | Fetal death 1 ☐Live birth Month in the past 12 months? Day 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s 2 No 1∏ Yes after death. Director: After this certific in by the funeral director, 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 200 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

egistrar NOV 1 5

31. Date filed (Month, Day, Year)

39 Registrar's Signature
Steem & Aparks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend state of Mary Det / the same at of the and whend Mygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Kosmakos 2007 Nov. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death

7. Age (In yrs. last birthday)

60

Phoenix
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

3:36 P <sup>M</sup>

Birthplace (State or Foreign Country)

Greece

<u>Baltimore</u>

Year)

Examiner **Funeral** 

Director

**Physician** 

/Medical

13716 Jarrettsville Pike

1 M 2 □ F

5. Social Security Number

047-48-6606

Usual Residence of Decedent

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner** 

within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

	10a. State	10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits
2013	MD	Baltimor	e	Pho	enix						1 □Yes 2√∑No
Ĭ	10e. Street and Nur	nber			1	Of. Zip Code			10g. C	Citizen of What Co	ountry?
Z L	13716 Ja	rrettsvil	le Pike			211	131		US	SA	
alle I	11. Marital Status		12. Was Decedent 8 Armed Forces?	er in U.S.	13. Was	Decedent of I	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No erto Rican, etc.)	)-	14. Race - Ame Black, Whit	
ر ا		ed 2 Married	1 ☐ Yes 2 ☐ XÎN If Yes, Give	No		Yes 2 XNo	Specify:	. ,			White
o o	3 Widowed		Year or Dates:	1 42					105		
lete		15. Decedent's Ed	ucation de completed)	16a	Give kind	's Usual Occup I of work done NOT use retire	pation during most of w d)	orking	160.	Kind of Business	rinaustry
duc	Elementary/Seco	* ` '	College (1-4or 5	·	_		·,			Restaur	ant
3	17. Father's Name		n/a		Owner		18. Mother's Na	ame (First, Middle	, Maide		arre
Ď C	John		Kosmakos				Dia	mitra	Ŧ	Begetis	
i		ame/Relationship (7					and Number or I	Rural Route Numb	er, City	or Town, State,	Zip Code)
	Mrs. Dimi	tra Kosma	kos/wife	1	3716	Jarrett	sville	Pike/Hoe	nix	MD 211	31
	20a. Method of Disp	oosition				n (Name of ory or other pla	. i	Date		Location - City or	
		☐Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	1			, 11,	/8/07 odox Cem	. Ba	altimore	, MD
9	21. 1979 Fu	rtije Spryice Livi	se A		22. Na	ame and Addre	ess of Facility				
ď	Bryan	W. Clary	Nur		Lem	mon Fun	neral Hon	me of Du	lane	y Valle	y, Inc.
	23a, Part1. Inter ti	n disease, or comp	olications that raused one can se on lach lin	the death. Do	not enter th	ne mode of dyi	ng, such as cardi	ac or respiratory a	arrest,	110 2109	Approximate Interval Between
	Immediat Cause (	Final	one carse on acri iii		1.	. 1	1.				Onset and Death
	disease o condition resulting in teath		a. Due to (or as	a consequence	of):	Tas	inve	- 0	35	-	nours
			Chappy	e also	Low	tive	ou lour	nary d	a CZ	24 60	NIONYC
1	Se uentially list con it any, leading to im	mediate	Due to (or as	a consequence	or):	217.	T. P. L. P. L.	The second	, ,		9001
	cause. Enter Unde Cause (Disease or that initiated events	injury	C								
ž	resulting in death) L		Due to (or as	a consequence	of):						
2			d								
200	IE EEMALE:								1		
AL D	IF FEMALE: 23b. Was decedent	i pregnant	23c. If yes, outcome 1□Live birth		h 3∐Ect	topic pregnanc	у		i	23d. Date of de	
2	in the past 12 1 ☐ Yes 2 ☐	No	4⊡Pregnant at 9⊡Unknown			her (specify) _				Month	Day Year
2	9 Unknown			sk mak na - siste - 1	in the	dulan access (	en in De d f	00- P'1	tobs==	une portale de la	o the serves of double
Š	Part II. Other signif	icant conditions co	ontributing to death bu	1	n the under	nying cause giv	ven in Part I.				o the cause of death?
20	- Viab	etes	Mell	tus	+1/	1		. 1	Yes	2 No 3 P	robably 4 □Unknown
ב								24a. Was	psy	24b. Were a	utopsy findings available completion of cause of
5								perfe 1∐ Yes	ormed?	death?	
0	25. Was case refer examiner?	-						eath (Check only			
2	1 ☐ Yes 2 🔀	140	Hospital: 1 ☐ Inpatie		·	3□ DOA Oth	4 ☐ Nursing	Home 5 Res			ecify)
5	27. Manner of Deat	h 5 ∐Pending	28a. Date of Injui		Time of Injury	28c. Inju	ry at rk?	28d. Describe	how inj	jury occurred	
IIICallon	2 Accident	investigation 6 Could not be				M 1 🗆	Yes 2 □ No				
	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of injubuilding, etc	ury - At home, fa c. <i>(Specify)</i>	arm, street,	factory, office		28f. Location ( City or To			lural Route Number,
ב כ											
2	29a. Certifier (Check only		ysician: To the best on niner: On the basis of	f examination a							
	one)		and manner sta								
4	29b. Signature and	nue or certifier	mo 1	MO	)	29c. Licens	957			Date signed ( <i>Mon</i>	
		9		11.7	•	1//	1,01		/	11 00	- /
- 1	OO Name and	and of parain die -	completed course of d	noth (Itom 22a)	/Tuno Drin	+)					

7801

**ORIGINAL** 

32 egistrar's Signature

Rd., Towson, MD 21204

DHMH 17 Rev 1/2001

State Registrar

Evangelos Lignos

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State	of Marylan	-	artment of F		and M	ental Hy		007	0.001
		Registrar  1. Decedent's Name (First, Middle	. Last)		Ce	illicate of	Deaiii		2. Date of De	Reg. No.	2001	3 5 3 3 1 3. Time of Death
Physicia		BARBAR	1 1	INE					Month	Day	Year 2 2007	6:09 PM
/Medic Examin	_	4a. Facility Name (If not institution		umber)		4b. City, Town, o	r Location o		AC OUNT		county of Death	· · · · · · · · · · · · · · · · · · ·
	2	HARBER	Hospin				LUTIA				,	
Funeral		5. Social Security Number 218-34-7111	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.	70 Yrs.	Months Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	Coun	
Director		Usual Residence of Decedent			70				Sept.	27,15	737	NY
ryland how		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation	-				1	Od. Inside City Limits
ne Ma 8a-f s otiffiec	Director		Arundel	Lin	thicum							1 ☐ Yes 2 📉 No
with the	Dir	10e. Street and Number 6440 Orchard R	ond			10f. Zip Code 21090					en of What Cour	itry?
death ms 23	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.	.S. 13.	Was Decedent of H	Hispanic Orig	gin? (Spe	ecify Yes or No	U.S.A	4. Race - Americ	
after or Iter		1 ☐ Never Married 2 🔀 Marri	Armed F ed 1 ☐ Yes	orces? 2 🙀 No live		If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican Specify:	ı, Puerto I	Rican, etc.)		Black, White,	
OUSO hours af ural", or	d by	3 ☐ Widowed 4 ☐ Divorced	Year or	Dates:								ite
n 72 h	Completed	15. Decedent (Specify only highes	t grade completed		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	t of workin	ng	16b. Kin	d of Business/Ind	dustry
Z   Z Z withi giene. r thar the M	mo	Elementary/Secondary (0-12)	College 3	(1-4or 5+)	Home	maker	,			Ow	m Home	
e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle,	,		•		18. Mothe	r's Name	(First, Middle			
yran Sould b Ment arked aric e	10	Lawrence Brenna					<u> </u>		ornton			
IOTE, INICITYICID Z I Z I 3-UU30 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentalla Hygiene. It of Health and Mentalla Hygiene. or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationsh				ng Address (Street				-		Code)
1 and 1 and Healt em 2		George F. Kline 20a. Method of Disposition	Jr. /Hus			Orchard osition (Name of matory or other pla					21090 ation - City or To	wn, State
Dallimore, permit. Pages 1 an Department of Heat Important; if item 2 any injury or other once.		1 XBurial 2 □Cremation 4 □Donation 5 □ Other (S		n State		matory or other pla l Vet.Cem		Nov. <sup>D</sup> 200			msville	
mit. F partm <b>sortar</b> / injui		21. Signature of Funeral Service		110		2. Name and Addre						
Dermi Depar Impon any ir		Selenals	Shirk	M014	79 s	ervices :	1 Seco	ond A	venue	SW G1	en Burn	ie, MD 2106
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	th. Do not en	ter the mode of dyir	ng, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	NTRAC		AL H	EMO	RRH	AGE			12 HOURS
Examiner			Due to	o (or as a conseq	quence of):						,	
	Je.	Sequentially list conditions,	b. Due to	o (or as a conse	uence of):							
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
cate be executed physician and the burial-transit		resulting in death) Last	Due to	o (or as a conseq	quence of):							
cate be e	dical		d									
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregna						23	3d. Date of delive	erv
death death de atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2□Feta gnant at time of c		∐Ectopic pregnanc ☐ Other <i>(specify)</i> _	У				Month	Day Year
requires that the een signed by the nould be detached	hys	9 □ Unknown	9□Unk									
res th	by	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	ınderlying cause giv	ven in Part I.	•	i	tobacco us Yes 2□		ne cause of death?
w requires been sign	eted											pably 4 MUnknown
The law ate has b	Completed								24a. Was auto perf		24b. Were auto prior to co death?	psy findings available mpletion of cause of
VICAL I		25. Was case referred to medical					26 Plans	of Dooth	1 Yes 1 (Check only	2 🖪 No		2 No
Or VItal Physician: rithis certific ral director,	To Be	examiner? 1 ☐ Yes 2 ∰ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3□ DOA Oth	or.				☐Other (Specif	v)
On O ding Ph fr. After th funeral		27. Manner of Death 1 ■ Natural 5 □ Pending	/h 4 a	e of Injury onth, Day Year)	28b. Time o	of 28c. Inju	ry at rk?	2	28d. Describe	how injury	occurred	
VISIO Attendi or death. rector: A by the fu	cati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation	na of inium. At h	ama farm of		Yes 2□I		oor t	(0)		
JIVI lor At after of Direct lin by	Certification:	4 ☐ Homicide determ	ined 28e. Plac buil	ding, etc. (Special	fy)	reet, factory, office		2	City or To	wn, State)	Number or Rura	li Houte Number,
spita nours neral y fillec		29a. Certifier 1 Certifyin	g Physician: To th	ne best of my kno	owledge, deat	th occurred at the ti	ime, date an	nd place,	and due to the	cause(s)	and manner as s	tated.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical	(Check only 2 Medical one)	Examiner: On the and ma	basis of examina inner stated.	ation and/or ir	nvestigation, in my		ath occurr	red at the time	, date and	place, and due to	o the cause(s)
To 1 To 1	Σ	29b. Signature and title of certified	100	11	7	29c. Licens		had -			signed (Month,	
		1 / ighal	MKan		<i>U</i>	Point N	=5 8	SPG		Nove	MBER 1	2,2007
b		30. Name and address of person	who completed car		m 23a) (Type,	Print)	1011-0	C	RA.	r.,	ne Mn	2,2007
	te	31. Date filed (Month Pay, Teat)		Registrar's Signa	adita si	T (A)	NOVER	1	UNU	IMO	ce, 1-11	41665

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Kern 12:39 AM NOV 2007 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NIA of Mamland Medical Center University If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1∏M 2□F Oct 1, Director 1930 Maryland 217-26-7171 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2♥ No MD Director Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be 17 E. Timonium Road 21093 USA or items 23a within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: white þ 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 0 Bethlehem Steel 12 steel worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nola Buckner Charles Edward Kern 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 93 Baldwin, MD 21013 Guy Kern Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Struice icensee Ronald Wade, State Anatomy Board 655 W. Baltimore Street Mirector Baltimore, MD 21201 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dan Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple mueloma Ire years /Medical Due to (or as a consequence of): **Examiner** 4 months Acute renal Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and -tran physician ar Due to (or as a consequence of) Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page certificate 2 N No 1∏ Yes director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of funeral 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 1 Natural Injury 5 Pending investigation

that the death certificate be executed Box 68760 Division or Vital Records, P.O. law requires The or Attending Physician: death. To the Funeral Director: completely filled in by the

hours after the Hospital

within 24

Baltimore, Maryland 21215-0036

2 Accident 3 ☐ Suicide 4 Homicide

(Check only one)

6 ☐ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number P21152 29d. Date signed (Month, Day, Year) Nov. 12, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ethel 4526 D. Weld Keswick Rd. Baltimore MD 21210

Registrar

Medical

31. Date filed (Month, Day, Year) NOV 1 5 2007

the Hospital or Atter ding Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours a er death.

within 2.

Cheryl Warnchell, M.D. 19241 Montgomery Village Avenue Suite E-10 Montgomery Village, MD 20886 32 pegistrar's Signature 31. Date filed (Month, Day, Year)

ddress of erson who completed cause of death (Item 23a) (Type, Print)

State Registrar

5

29b. Signature and title of certifier

29c. License number

D14555

29d. Date signed (Month, Day, Year)

Vovember 15, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. nd 40 now State of Maryland / Department of Health and Mental Hygiene 007

			For Amend #8 Per	State of Mar FH g873 1	Yland/Pepa Ce	artment of He Hillicate of D	ealth and Mental Death	Hygien Reg. N	2007	36594
S	Dharisi		Decedent's Name (First, Middle, Last)		<del></del>	-	2. Date Mont	of Death h D	ay the Year	3. Time of Death
4	Physici /Medic		FAYE LO	VELL			Nov	EMBER	1112007.	12.50
	Examin	er	4a. Facility Name (If not institution, give st			4b. City, Town, or		Į.	c. County of Death	
	× L		Northwest Hospita  5. Social Security Number 6. Sex		(In yrs. last birthday)	Randalls If Under 1 Year			Baltimore	ace (State or Foreign
L	Funeral Director			/ 2 <b>⊠</b> F	60 Yrs.	Months Days		of Birth th, Day, Year		ace (State or Foreign try)
į,	D		Usual Residence of Decedent							
	ırylan show	_	10a. State 10b. County		10c. City, Town or Lo	cation			10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	ne Ma 8a-f s ptiflec	Directo	Maryland Baltimor	e City	Baltim			100 0	200	
	with the		10e. Street and Number 2008 Deering Ave.			10f. Zip Code 21230			Citizen of What Count	
	eath	eral		. Was Decedent Ev	ver in U.S. 13.		spanic Origin? (Specify Yes		ited State	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	1 □ Never Married 2 □ Married  3 ★★Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2XX\\ If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes ※ No	spanic Origin? (Specify Yes n, Mexican, Puerto Rican, et Specify:	c.)	Black, White, e	
21215-0036	2 hou atura ical E		15. Decedent's Educa (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Business/Ind	lustry
218	within 7 iene. than 'r the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	)		luring most of working )			
2	e filed within al Hygiene. I other than '	S	11		Hom	emaker	10 Mathada Nama (First A	Aiddle Afeid	Own Ho	me
Maryland	ould be fil Mental H arked otl atlc even	Be	17. Father's Name (First, Middle, Last)  Robert L. Lewis				18. Mother's Name (First, Marketty Patt		en Sumame)	
3	2 should be and Menta is marked raumatic ev	유	19a. Informant's Name/Relationship (Type	Print)	19h Maili	ng Address (Street a	and Number or Rural Route		v or Town. State. Zip	Code)
Ma	id 2 s ith an 17 is i		Brian Lovell / So					•		,
ē,	s 1 and 2 f Health tem 27 i		20a. Method of Disposition		20b. Place of Dispe	Deering A sition (Name of matory or other place	Date /	20c.	D 21230 Location - City or To	wn, State
9	Pages nent of l int: If Its iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metro Cre		2007	Cat	tonsville,	MD
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	ansk	ĸ	2. Name and Addres irkley-Rud 421 Crain	s of Facility ddick Funeral Hwy. S.E. Gl	Home en Bui	P.A. MD 2	1061
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused t						Approximate Interval Between
	Physician		Immediate Cause (Final			STRUCT	1.7		la Na	Onset and Death
a	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	2 INDC	ive turn	2 1111	A DIN	21736
E	Examiner		Sequentially list conditions b.		SHEES -	Tive )	HEART F	TILL	SRE!	
7	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):			0		
/	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last		consequence of):	Cal	opmaias	MATH	17.	
8760,	cate be executed oblysician and the burial-transit			,	. ^	KALEN	M			
687	ficate g phys	edic	a.	-						
P.O. Box	the death certificate the attending physiched for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome p 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
	requires that the de een signed by the a hould be detached i		Part II. Other significant conditions conf	ributing to death but	not resulting in the	inderlying cause give	en in Part I. 23e	. Did tobacc	o use contribute to the	ne cause of death?
rds	w requires been sign should be	ed by						1 Yes	2 No 3 Prob	pably 4 □Unknown
or Vital Records,	> 10 0	Completed					248	. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Ä	e – e	lmo;					10	performed Yes 2	?   death?	2 <b>X</b> No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			- 22.5	26. Place of Death (Check	only one)		ρ
7	Physician: this certification director, is	은	1 ☐ Yes 2 No	ospital: 1 N Inpatien			4   Nursing Home 5			y)
n		ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Worl		scribe how in	njury occurred	
isio	Attending r death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injur	y - At home, farm, st		Yes 2 □No	ation (Street	and Number or Rura	al Route Number.
Division	or Attendater death Director:	Certification:	4 Homicide determined	building, etc.	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City	or Town, St	tate)	
	Hospita 4 hours Funeral	Medical C			examination and/or i		me, date and place, and due pinion, death occurred at th			
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0	· 11. ~	29c. License			Date signed (Month,	III
			> Xuxinin	• • • • •	419		1410		ovember 11	,2107.
	6		30. Name and address of person who con	npleted cause of de	ath (Item 23a) (Type	Print) JoG	NOER P ME	MITA	-	
			31. Date filed (Month, Day, Year)	OJVITAL 32 Bagistra	CENTE	RAM	NOMUSTOW	M M	10 2113	3.
1.	Sta Regist			32 Règistra	A A	and the				
Di		001	NOV 1 5 200	1 January 1	1 1 1					

DHMH 17 Rev 1/2001

Box 68760,
P.O. E
Records, I
or Vital
Division

		State of Maryland / Departme	nt of Health ate of Death		_ /	36595
- 4		1. Decedent's Name (First, Middle, Last)	ile of Death	2. Date of D	Reg. No.	3. Time of Death
Physicia /Medic	al	Walter R. Lutter		Month Nov.	Day Yea 12 200'	7 1-1-5 P-M
Examin	er	4a. Facility Name (If not institution, give street and number)  VP MARYLANA HEALTH CARE SYSTEM  4b. City	y, Town, or Location	OF Death	4c. County of De	eath E/L
Funeral Director		5. Social Security Number  105-16-9728  6. Sex 1		Min. 8. Date of B (Month, D	ay, Year)	Birthplace (State or Foreign Country) New York
pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryla f shor	to	Maryland Baltimore	M	iddle River		1 ☐Yes 2€ No
n 28a-	0		ip Code	20020. 212702	10g. Citizen of What	Country?
23a c		201 Middleway Road Apt. 1D	21220		United	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 □ Never Married 2 □ Married   1 ☑ Yes 2 □ No WWII   If Yes, Give		origin? (Specify Yes or N an, Puerto Rican, etc.) V:	o- 14. Race - Ai Black, W Specify:	
hours	ed b	15. Decedent's Education 16a. Decedent's Us			16b. Kind of Busine	White ss/Industry
thin 72 e. an "na Medic	Completed	(Specify only highest grade completed) (Give kind of w Elementary/Secondary (0-12) College (1-4or 5+)	vork done during mo use retired)	ost of working		
led wi lygien her th nt, the	် ပ	12 Years Iron Wo		her's Name (First, Middl	Steel Inc	dustry
d be fi ental F ced ot c ever	To Be	William Lutter	10. 19100		aroline Kud	cera
shoul and M s mar	F	( ), (	•	ber or Rural Route Num		
and 2 ealth an 27 i				t Drive Pe		
Pages 1 nent of Ha int; If iter iry or oth		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition (N cemetery, crematory or		11-19-2007	20c. Location - City	
permit. Pa Departme Important any injury once.		4 Donation 5 Other (Specify) Garrison For  21. Signature of Funeral Service Licenses 22. Name	and Address of Faci	ility		Mills, MD
permi Depai Impoi any ir		hall Fally Duda-17922 V	Ruck Fune Nise Ave.	ral Home of Dundalk,	Maryland 21	1nc. 1222
		23a. Part1. Enter the disease, or complications that used the death. Do not enter the m shock, or heart failure. List only one cause on ach line.	ode of dying, such a	as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   CONGESTIVE HEART F  Due to (or as a consequence of):	AILURE			DIAKNOMN
Examiner		ADRTIP STENDSIS				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
cate be executed bhysician and the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):	·			
e be e /sician	dical E	d				
rtificat ng phy	Medi	IF FEMALE:			-	
Attending Physician: The law requires that the death certific reder: After this certificate has been signed by the attending pby the funeral director, page 2 should be detached for use as to the funeral director.	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic  4 ☐ Pregnant at time of death 5 ☐ Other (9 ☐ Unknown)			23d. Date of Month	delivery Day Year
siclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part			e to the cause of death?  Probably 4 Dunknown
w requ	Completed			24a. Wa	s an 24b. Were	autopsy findings available
The la	omo			——— aut per 1∐ Yes	formed? death	
iclan: sertific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	1000	ce of Death (Check only		
Physi r this o	۲.	1 Yes 2 1 No Inpatient 2 ER/Outpatient 3 1 27. Manyler of Death 28a. Date of Injury 28b. Time of		Nursing Home 5 Re	sidence 6 Other (S	Specify)
th. :: After	ition	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M	28c. Injury at Work? 1 ☐ Yes 2 [			
or Atter ter dea iirector n by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location City or T	(Street and Number or own, State)	Rural Route Number,
pital cours af	Cel	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurry	ed at the time, date	and place, and due to the	e cause(s) and manne	r as stated.
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only cone)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ion, in my opinion, d	leath occurred at the tim	e, date and place, and	due to the cause(s)
Mithi To t	Ž	ON LANGERE	29c. License number	726926	NOVEMBER	
HXI		30. Name and address of person who completed cause of reath (Item 23a) (Type, Print)  A E DORNH BULLOEK, M. D. VN MARY LAND HEAD  31. Date filled (Month, Day, Year)  NOV 1 5 2007	TH SYSTE	M, PERRY I	DM, THIOA	21902
Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 5 2007	9			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes

			For State Registrar	State of Mai	ylaria /		rtificate of		ia iviei		Reg. No.	2007	36596
	Physici /Medic		Decedent's Name (First, Middle, Last Ralph Luca	)						Date of Dea Month JVEMB		14. Žear	3. Time of Death
	Examir		4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical	Cent	e 1*	4b. City, Town, o		OWSOI			County of Dea Ba	n Ltimore
F- 1	Funeral Director		217-34-0043	x 7. Age XIM 2□F 84	(In yrs. last t	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Min. Ju	Date of Birth (Month, Bay INC 18,	1923	9. Bir Ita	thplace (State or Foreign Lintry)
	e Maryland a-f show iffied at	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City, To Balt	wn or Lo							10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28 ist be no	Funeral Director	10e. Street and Number 6511 Laurelton Avenue				10f. Zip Code 21214			1	-	en of What Co	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funer	11. Marital Status  1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	ispanic Origin an, Mexican, F <i>Sp</i> ec <i>ify:</i>	n? (Specify Puerto Rica	Yes or No- an, etc.)		4. Race - Ame Black, Whit Specify: Wh	e, etc.
215-0	hin 72 ho e. In "natu Medical	Completed by	15. Decedent's Edu (Specify only highest grad	ucation fe completed) College (1-4or 5+)		(Give life. I	dent's Usual Occup kind of work done DO NOT use retired	ation during most of d)	of working			d of Business	/Industry
Maryland 21215-0036	d be filed wit ental Hygiene ced other the cevent, the	To Be Com	Elementary Secondary (0-12)  17. Father's Name (First, Middle, Last) Paul Luca			Tailo	or	18. Mother's	s Name <i>(Fi</i> Oria Gu		Cloth Maiden S		
Maryl	nd 2 shoul alth and Me 27 is mark r traumati	ř	19a. Informant's Name/Relationship (7) Rose Luca/ Wife	ype. Print)	15	9b. Mailir 6511	ng Address (Street 1 Laurelton	and Number of Avenue	or Rural Re Balti	oute Numbe I <b>more</b> I	r, City or Maryla	Town, State, and 212	Zip Code) 14
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			op Ser	esition (Name of matory or other place rvice Corp.	1	Date	07	Tows	ation - City or SON Mary	
Balt	permit. Departr Importa any Inji		21. Signature of Funeral Service Licens	Vito		122 13	2. Name and Addre eonard J. R 305 Harford	ss of Facility UCK, INC Road P	Raltimo	ore Mari	vland	21214	
i i	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a. <u>FLASH</u>	PULM(	o not ent		ng, such as ca					Approximate Interval Between Onset and Death
	/Medical Examiner			b	STIVE	HEA	ART FAIL	URE					
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	IIC C	ARDI	COMYOPAT	ГНҮ					
68760,	icate be executed physician and s the burial-transit	Aedical Ex	resulting in death) Last	Due to (or as a CORONF			RY DISER	ASE					
Box.	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal dea		□Ectopic pregnanc	ý			23	3d. Date of de Month	livery Day Year
ls, P.O.	ires that the de signed by the a be detached t	by	Part II. Other significant conditions of CHRONIC RE			j in the u	nderlying cause giv	en in Part I.		23e. Did to			o the cause of death?
or Vital Records,	aw requir is been si 2 should b	Completed	DIABETES M			)				24a. Was a	an	24b. Were a	utopsy findings available completion of cause of
tal R			25. Was case referred to medical			-		26. Place of	of Doath (C	perfor 1∐ Yes	med? 2 No	death?	s 2□ No
>	S S	o Be	examiner?	Hospital: 1 🕱 Inpatient	t 2 ER/0	Outpatien	nt 3□ DOA Oth	or.			_ ^-	□Other (Spe	ecify)
	ffer The	tion: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day		i. Time o	Wor		28d	. Describe h			
Division	al or Attend after death. I Director: / d in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injur building, etc.	y - At home, (Specify)	farm, str	reet, factory, office		28f.	Location (S City or Tow	Street and m, State)	Number or R	ural Route Number,
$\left( \right)$	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		vsician: To the best of iner: On the basis of and manner state	examination								
	To t To tl	M	29b. Signature and title of certifier	en s		>	29c. Licens	e number 7254			29d. Date	signed (Mon	th, Day, Year)
	5		30. Name and address of person who of BOON POH LIM	NA 15 77 77	na men	CT CT	TOTHE	TOWSO	ON. I	MARYL	AND	21204	+
	Sta Regist		31. Date filed (Month, Day, Year) NOV 1 5 200	32. Registrar	's Signature	dos	all .						

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, <

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	epartment of Health and M Certificate of Death	Reg. No.2007	36597			
	Physici		1. Decedent's Name (First, Middle, Last)  Prodrew & Lambros		2. Date of Death Month Day Year  NUU 11 2007	3. Time of Death			
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dear				
			Victorian Estates	Bel Air	1 Lau Sound	2			
	Funeral Director		5. Social Security Number 213−14−0852 6. Sex 1 M 2 F 7. Age (In yrs. iast birtho	Months Days Hours Min	8. Date of Birth (Month, Day, Year) 9. Birth Co Jan. 30, 1916 Mar	hplace (State or Foreign Juntry) Yland			
aryland	show od at	2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location		10d. Inside City Limits 1 ☐ Yes 2 XNo			
the M	28a-f	ecto	Maryland Harford Bel Air	10f. Zip Code	10g. Citizen of What Co				
with	Sa or	Ö	216 Victory Lane	21014	USA	army;			
72 hours after death with the Maryland	items 2	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Dever Married 2 Married 1 Deserver Married 2 December 1 Deserver Married 2 December 1 D	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto					
ours af	ral", or Exam	b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🙀 No <i>Specify:</i>	Specify:	hite			
	nt of neating and wentar Inglene. If them 27 is amended other than "natural", or items 23a or 28a-f show If item 27 is amended other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of worki fe. DO NOT use retired)	ing 16b. Kind of Business/	Industry			
filed within	lygien rt, the			er/Operator	Restaurant	:			
be fi	and Mental Hyglene. Is marked other than aumatic event, the Me	Be	17. Father's Name ( <i>First, Middle, Last</i> )  Nicholas A. Lambros	Stella	(First, Middle, Maiden Surname) (nmn) Fiqueroa				
should be	mark matic	오		failing Address (Street and Number or Rura		Zin Code)			
nd 2 s	27 Is			6 Victory Lane, Bel		up code)			
es 1 a	item rothe		20a. Method of Disposition 20b. Place of D cemetery,	isposition (Name of crematory or other place)	Date 20c. Location - City or	Town, State			
rmit. Pages	ant: If		X Dullat 2 Defination 3 Definition State 1	orthodox Cem. 11-1	3-07 Baltimore,	Maryland			
permit.	Department of health a limportant: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee	22. Name and Address of Facility McComas Funeral Ho 1317 Cokesbury Roa	me, P.A.	and 21009			
-	ysician ledical		23a. Part. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Due to (or as a consequence of)	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death  ice eles			
ificate be executed vi	physician and stree burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
The law requires that the death certific	been signed by the attending p should be detached for use as !	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of del Month	ivery Day Year			
w requires that	n signed by	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use contribute to				
The law re	SS	Completed	C 12 K		autopsy prior to performed? death?	utopsy findings available completion of cause of 2 ☐ No			
cian:	sertific actor,	Be	25. Was case referred to medical examiner?		(Check only one)	of Esistant Lin			
Phys	rthis or	. To	1 Yes 2 No Hospital: 1 Inpatient 2 Fe/Outpa 27. Manner of Death 28a. Date of Injury 28b. Tim		me 5 Residence 6 Other (Spe	city)			
tending	eaun. Ior: After the fune	Certification:	1 ☑ Natural 5 □ Pending (Month, Ďaý Year) Inju 2 □ Accident investigation	work?  M 1 Yes 2 No					
tal or At	s aner or al Direct ed in by	Sertifi	4 Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,			
e Hospit	within Extractions are to be and within a certificate he completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, concluded the control of the basis of examination and/control one)  12 Certifying Physician: To the best of my knowledge, control one of the basis of examination and/control one of the basis of the	death occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause(s) and manner as red at the time, date and place, and due	s stated. e to the cause(s)			
Toth	To the confidence of the confi	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)			
			Wind Klex no	D31295	11/12/02				
16	)		30. Name and address of person who completed cause of death (Item 23a) (Ty 670) Al Charles St Suite 7262	pe, Print) Wendy Klosez,	MD • Y				
H	Sta Registr		31. Date filed (Month, Day, Year) 2007 32. Registrar's Signature	carli					

29c. License number

000

29d. Date şigned (Month, Day, Year)

Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

20

32. Registrar's Signature 31. Date filed (Month, Day, Year) **ORIGINAL** 

who completed cause of death (Item 23a) (Type, Print)

UL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 36599 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year 5:00 AM linton November 15200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A larbor Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. S 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 ☐ F Yrs Sept. 6, 1919 Virginia Director 88 <u>226-24-4476</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural", or items 23a or 28a-f show dical Examiner must be notified at 1 X Yes 2 No Director Brooklyn Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 U.S.A. 4024 6th Street Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No White 1 ☐ Yes 2 ♠ No Specify Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel 8 Shipfitter other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McDorman Nellie Reedy Floyd ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4024 6th Street, Baltimore, Maryland 21225 (Son) Ronald E. McDorman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 11-16-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 237 E. Patapsco Avenue, Baltimore, 21. Signature of Euneral Service License Maryland 21225 22 part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final isease or condition resulting in death) **Physician** rostate /Medical Due to (or as a consequence of): Examiner lostructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed A pue burial-trans holangitis Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Dav Vear 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown cate has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1∐ Yes 2000 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Thipatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

Division or Vital Records, P.O. Box 68760, Physician: or Attending filled in by

Maryland 21215-0036

Baltimore,

within 24 hours after death To the Funeral Director: Hospital completely

State Registra

31. Date filed (Month, Day, Year) NOV 1 5 2

29a. Certifier

one)

(Check only

29b. Signature and title of certifier

29c. License number ROOL

1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) November 15 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 South Hanover St. Baltimore MD 21225 ith, Day, Year) 32. Registrar's Synature

and manner stated.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physici**an MILLER NOVEMBER 10, 2007 GEORGE 05:44 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL SATIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Sept. 16, Social Security Number 7. Age (In yrs. last birthday) 92 Yrs. 9. Birthplace (State or Foreign Funeral 5, 1915 216-07-6223 **X**□M 2□ F Months Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland 1 XYes 2 ☐ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3300 Benson Ave. Completed by Funeral 21227 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Truck Driver</u> Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Henry Miller Margaret Meedter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Byrum, daughter 2819 Florida Ave. Baltimore, MD. 21227 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition Loudon Park Cemetery 11-14-07 1X Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END ORGAN FAILURE SECONDARY TO SEPTIC SHOCK Due to (or as a consequence of): 24 hours KIGHT LOWER LOBE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION CARDIOMYOPATHY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAR FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform BLADDER CANCER 1∐ Yes 25. Was case referred to medical examiner? 1 \( \text{Yes} \) Yes 2 \( \text{Y} \) No Be 26. Place of Death (Check only one) Hospital: 1 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 ☐ Accident

Examiner P.O. Division or Vital Records,

burial-tran the To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death \( \) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Examiner must once.

**Physician** /Medical

Baltimore, Maryland 21215-0036

6 ☐ Could not be

determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

3 Suicide

29a. Certifier

Medical

4 Homicide

20000

November 10, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HANGUER STREET BALTIMORE MARYLAND 21225 JOUTH

31. Date filed (Month, Day, Year) State NOV 1 5 2007 Registrar

2. Registrar's Signature

Physicia /Medic Examin

Funeral Director

	Please	Type or Print in				•	•	le.
1 - For State Registrar		State of Maryla		artment of H <i>rtificate of L</i>			en <b>2</b> () ()	7 36601
	me <i>(First, Middl</i> e, Las RICIA		1CCREARY	Ĭ.		2. Date of Death Month NOV 5, 2	2007	Year 2250 N
4a. Facility Name	(If not institution, give			4b. City, Town, or AAFB	Location of Death		4c. County o	
5. Social Security 213-42- Usual Residence	9966	9X 7. Age (In yr	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) June 3,		9. Birthplace (State or Foreig Country) Mississippi
10a. State	10b. County Prince Ge		city, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
10e. Street and N 4812 Me1	lumber			10f. Zip Code 20772			S.A.	hat Country?
11. Marital Status		12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No-	14. Race	- American Indian, , White, etc. White
(Sp	15. Decedent's Ed	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	uring most of work	ing 16	6b. Kind of Bus	iness/Industry
12	e (First, Middle, Last)	4	Nurse	е	18. Mother's Name	a (First, Middle, Ma	Health aiden Sumame	
	. Mulhall				Ruth Jou	9		
	Name/Relationship (Technology)  CCreary (Helisposition)	usband)	4812	ng Address (Street a  Me1wood I  position (Name of	Rd. Upper	Mar1bor	o, MD 2	
1 ☑ Burial 4 🖰 Donation	2 Cremation 3 1 1 1 5 Other (Specify Funeral Services Licen	Removal from State  /)  Ma	cemetery, cres aryland	Veterans 2. Name and Addres	Nov.	14,2007	Chelten	ham. MD
460	-59HO	MO146  Dilications that caused the de	7 00	533 Uld A.	lexandria	Ferry Ko	d. Clin	ton, MD 20735
Immediate Caus disease or condi resulting in dealt Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death	e (Final tition 1)  conditions, immediate derlying or injury tits	b. Due to (or as a cons  Due to (or as a cons  Due to (or as a cons  c. Due to (or as a cons  d.	equence of):					Onset and Death
IF FEMALE: 23b. Was deceded in the past 1 Yes 2 Unknow	12 months? 2 No	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delivery th Day Year
	nificant conditions o ERM TOBBAC	ontributing to death but not r	esulting in the u	underlying cause give	on in Part I.		_	bute Io the cause of death?
						24a. Was an autopsy performe	ed? de	fere autopsy findings available for to completion of cause of eath?  Yes 2 No
25. Was case ref examiner?		Hospital:		Dthe	ar-	h (Check only one,		
27. Manner of De	5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	of 28c Injury	4   Nursing Ho	me 5 Residen 28d. Describe how		
2 Accident 3 Suicide 4 Homicide	6 Could not be					28f. Location (Stre City or Town,		r or Rural Route Number,
29a. Certifier (Check only one)	1V Certifying Ph 2 Medical Exam	ysician: To the best of my k niner: On the basis of exam- and manner stated.	knowledge, deat ination and/or in	th occurred at the timestigation, in my op-	e, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and man e and place, a	nner as stated. nd due to the cause(s)
29b. Signature at	nd the of certifier	de la la la la la la la la la la la la la		Michi 43010	number gan 82463	290	_	(Month, Dey, Year) , 2007
		completed cause of death (IIII) D 1050 W. Per			ews_AFB.	MD 20762		
31. Date filed (Mi		32 Segistrar's Sig	gnature	all)				
	1101 4 0 7	The state of the s	1 15				-	

DHMH 17 Rev 1/2001

Sta Registr

10

ORIGINAL

Registra DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 15

32. Registrar's Signature

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland		artment of H <i>tificate of l</i>				e 2007	36604		
*.	Physicia	an	1. Decedent's Name (First, Middle, Las	t)	Mo	PVA	!ter		2. Date of De Month	eath Da	ay Year	3. Time of Death		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	7 . C	C 1 0	4b. City, Town, or	Location of Death	November		12 200 To. County of Dea	ath		
	LAGIIIII	er		load			Randali	Istown				imone		
E.	Funeral Director		210-09-7240	ex 7. Age M 2□ F	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir July 23	th 3, 19	18 9. Bi	rthplace (State or Foreign Country) MD		
	land ow at	Director	Usual Residence of Decedent  10a. State									10d. Inside City Limits		
	a-fsh		MD Baltimor	e	Randa	andal1stown					1 Yes 2 No			
	be filed within 72 hours after death with the Maryland Hygliene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		10e. Street and Number			10f. Zip Code					itizen of What C	Country?		
036			9206 Liberty Road		in II C	10.1	21133	innerio Origin? (C	nacify Vac or No		S.A.	perican Indian		
		by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □ Yes 2∑ No	Specify:	o Rican, etc.)	J-	Black, Wh	ite, etc.		
Maryland 21215-0036	n 72 h "natu edical	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Deced (Give life. I	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of wor d)	rking	16b.	Kind of Busines	s/Industry		
212	y withi giene. r than the M	mo	Elementary/Secondary (0-12)	College (1-4or 5-			Driver	,		Oi	1 Compa	ny		
b	al Hyg l othe vent,	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name				e (First, Middle, Maiden Surname)					
<u>   </u>	should and Mer s marke		John Meerdter		Mary Dorr									
Nar			19a. Informant's Name/Relationship (7) Mrs Ruth A. Meerd	• •			ng Address (Street Liberty							
	1 and 2 Health Iem 27 i		20a. Method of Disposition	LCI/ WIIC	20b. Plac		sition (Name of matory or other place	1	Date		Location - City of			
altimore,	Pages nent of ant: If its ury or o		1X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other ( <i>Specify</i>		1		matory or other place.  Mem.Par		. 17, 07	Sy	kesvill	e, MD		
Balt	permit. Page Department Important: If any Injury o		21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services 1 Second Avenue SW Glen Burnie, MD 2106											
Р		iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between											
	Physician /Medical		Immediate Cause (Final disease or condition a. Alzheimer's disease Years									Onset and Death YearS		
	Examiner			Due to (or as a	a consequer	sequence of):								
	p ##		Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or Injury	Due to (or as a	a consequence of):									
2-	kecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):									
68760,0	ficate be executed physician and is the burial-transit	edical E		<b>▼</b> d										
	4- 00		IF FEMALE:							1				
, P.O. Box	at the death certif by the attending tached for use as	Medical Certification: To Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown								23d. Date of delivery  Month Day Year			
	res that signed by be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did toba							tobacco	acco use contribute to the cause of death?			
g	The law requi te has been s		1 U Y							Yes	es 22 No 3 Probably 4 Unknown			
Vital Records,			24a. Was an autopsy performed 1 □ Yes 2 ✓							opsy formed,?				
Vita	slcian certific ector,		25. Was case referred to medical examiner?  26. Place of Death (Check only one)											
ō	Phys rrthis eral dii		2   Producting   200   Time of   200   Description   200   Descrip								pecify)			
Division or	To the Hospital or Attending Physician: within 42 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p		27. Manner of Death  1. Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 4 Work?  28d. Describe here of Injury 4 Work?  1 Yes 2 No											
			3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	le Hospit 124 hours te Funera		29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the To the Comp	Me	29b. Signature and title of certifier	ν	no		29c. Licens				Date signed (Mo			
,	.0		30. Name and address of person who	completed cause of de	eath (Item 2	За) (Туре,	Print)	1/04	1 - 1	, , , , , , , , ,	omoer 1	3 2007		
	10		D Roggen 5400 0	1d Court Re	sud S	mite 1	108 Ran	dallslown	no		4133			
	Sta Registi		D Rogger 5400 0 31. Date filed (Month, Day, Year) NOV 1 5 200	7	a s Signatul	Local	E.							

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 7

36605

							Cert	ificate of	Death		Reg. No.				
			1. Decedent's Name	e (First, Middle, La	st)	,				2. Date of De Month	_	Year	3. Time of Death		
	Physician		BARBARA D. MEHL								November 05 2001 2250				
	/Medica Examine		4a Facility Name (/	f not institution, giv	e street and number)				4b. City, Town,	or Location of Deel	h 4c. County o	f Death			
1	LAdmine		GLADE	VALLEY	NURSING	and K	ehak	, S	Walkers	suille	FREC	lerei	ck		
	Funeral		5. Social Security N	lumber 6. S	ex 7. Ag	e (In yrs. last	birthday)	If Under 1 Year		Irs. 8. Date of Bi	rth	9. Birthpla	ce (State or Foreign y)		
и	Director		496-30-29	955	□M 2∏ F	81	Yrs.	Months Days	Hours		6, 1926				
	-		Usual Residence of												
	ylend Mor		10a. State	10c. City, T	own or Loce	etion			10d. Inside City Limits						
	Mar T	ខ្ព	MD Frederick Frederick										1 □ Yes 2√√ No		
	28	<u></u>	10e. Street and Nur							10g. Citizen of What Country?					
	3a o	Funeral Director	815 Mont	claire A	venue				21701		USA				
	ms 2	٦	11. Marital Status		12. Was Decedent Ever in U, Armed Forces?		13. W	as Decedent of I	Hispanic Origin?	(Specify Yes or N lerto Rican, etc.)	o- 14. Race	- American			
21215-0020	flar	2	1 🖺 Never Marri	ied 2 Married	1 ☐ Yes 2 🛣 No					erio riioari, etc.)	Market Ma				
	within 72 hours aftar death with the Marylend ene. than "naturel" or items 23s or 28s-f show the Medical Exerciner must be notified at	۵	3	4 Divorced	If Yes, Give Year or Dates:			□Yes 21X No	Specify:		Specify:	wni	ite		
	2 ho	Completed	/0	15. Decedent's Ed	ducetion	1	6e. Decede	ent's Usuai Occu	pation	working	16b. Kind of Bus	16b. Kind of Business/Industr			
215	hin 7	ᇍ	Elementary/Seco	only highest greendary (0-12)	College (1-4or 5	i+)	life. De	O NOT use retire	during most of ved)						
7	d with giena. r thar	6	12		5+		cler	gу			relig				
	Hygid other	Be C	17. Father's Name	(First, Middle, Lest,	)				18. Mother's N	Name (First, Middle	e, Maiden Surname	9)			
<u>a</u>	Mantel American	0	Purd Eug	gene Deit	z				This	be Shultz					
Maryland	2 should be and N is man	Ţ	19a. Informant's Na	ame/Relationship (	Type, Print)		19b. Mailing	Address (Stree	t and Number or	Rurel Route Num	ber, City or Town,	State, Zip C	Code)		
Ž	nd 2 lith e 27 is		Mary Mel	n1/daught	er		815	Montcla	ire Ave	nue Frede	e Frederick, MD 21701				
ē,	igas 1 and 2 should be filad within 72 hours aftar death with the Manylen it of Health end Mantel Hygiena. If Item 27 is marked other than "natural," or items 23s or 28s-f show or other treumstic event, the Madical Examiner must be notified at	1	20a. Method of Disp	position		20b. Plac	e of Dispos	ition (Name of atory or other pla	ace)	Date	Date 20c. Location - City or Town, State				
5	ant of t: If it y or o			☐ Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	Com	olory, cronn	atory or other pre	.00)	ļ					
Baltimore,	permit. Pegas 1 end Depertment of Health Important: If Item 27 any injury or other to once.	1					22.	Name and Addr	ess of Facility	1 (55.1	T. D.144		Stroot		
Ba	permit. Depentimportu		R	onald S.	Wade, Dir	ector			_		W. Baltin	iore a	olieet		
			Aus	21/	ral			altimore	•	1201			A		
			23a. Part1. Enter to shock, or hea	he disease, or cort art failure. List only	ofications that caused one cause on each li	the death. ne.	Do not ente	r the mode of dy	ing, such as card	glac or respiratory	arrest,		Approximate Interval Between Onset and Death		
	Physician				1		1	1		1. 1			onsol and boatt		
	/Medical	1	Immediate Cause disease or condition	on	· CA	ulx	alare								
	Examiner		resulting in death)			Due to (or a	s a consequ					1			
	D .=			_	_							1			
	ifficeta be executed g physician and es the buriel-transit	/Medical Examiner	Sequentially list co	onditions,	D	Due to (or a	s a consequ	ence ol):							
o,	an a	Ĭ.	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying											
68760,	sentificeta be execui ding physiclan and sa es the buriel-trar	<u> </u>	that initiated events	5	C	Due to (or as	s a consequ	ence of):		-					
	tifice ng ph es ti	<u>8</u>	resulting in death)	Last											
Вох	n certifi ending usa es	d													
	v requires that the death or been signed by the attend should be detached for us	Completed by Physician	Part II. Other signif	ficant conditions	ontributing to death b	ut not resulti	ng in the un	derlying cause g	iven in Part I.	23b. Die	i tobacco use con	tribute to	the cause of death?		
P.0	by the	Ě	110	-11	11.11/101	,	1 -	1	10	1 □ Yes 2 No 3 □ Probably 4 □ Unknown					
	than ned del	Ž.	. what ferrenamed imperiension												
al Records,	requires that the	8	strope ( cognitive inguisment							24a. Wa	24a. Was an autopsy performed? 24b. Were auto				
	A rec	et								_			pletion of cause eath?		
	The lew ete has t paga 2 s	Ĕ								10	Yes 20 No	1 🗆	Yes 2□ No		
	Ficete		25. Was case referred to medical  26. Place of Death (Check only one)												
of Vital	2 2 2	8 B	examiner?	,	Hospital:		2/0	0 DOA 0				ar (Specify	1		
o	Phys this rat di	<u>۹</u>	1 ☐ Yes 2 ☐ 27. Manner of Deat		1 ☐ Inpation	- 1	NOutpatient  Bb. Time of				5 ☐ Residence 6 ☐ Other (Specify)  Describe how injury occurred				
5	Ing I	<u></u>	Neturel	5 Pending	(Month, De		28c. Injury at Work? 1 ☐ Yes 2 ☐ No								
Division	Attending in death.  Softon: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investigation	28e. Place of injury - At home, larm, street, I					281 Location	281. Location (Street and Number or Rural Route Number,				
₹	or At franc direct in by		4 Homicide	determined	building, et	o, raim, stro	, tarm, street, lactory, onice			City or Town, State)					
	To the Hoepital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral	edical Certification:	00- 0-2"	Acres 11 m	lelen. T- the b	of my length	adaa daash	acquired at the	urred at the time, date and place, and due to the cause(s) and manner as stated.						
	Hoer 24 ho Fune taly f	Ca	29a, Certifier (Check only	2 Medicai Exa	miner: On the basis of	f examination	n and/or inv	estigation, in my	opinion, death o	occurred at the time	, date and place,	and due to	the cause(s)		
	the the I	Neg Neg													
	o i i i i		290. Signature and	Title or certifier	////	111			201	02	N		2 2 -		
			My Shouth MD 133183 November 1 2007												
			30. Narry and address of person who completed cause of death (Item 23a) (Type, Print)  A Cock tell 300 West of for frederick, MD												
			HI	J. B	to Gook	186	5	00 0	1050 /	57.	11 CCTE	VIC	(10018)		
	Stat		31. Mate filed (Mor	10.00		rar's Signatui	Aces.	De P							
	Registra	ır 🐰	NO	V 1 5 200	7 The se-	1 15	A STATE OF THE PARTY OF THE PAR	E-M-							

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 36606 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:30 AM M 2007 October 26, Charles Edward Marx /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore CockeysVILLE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. May 10, 1 Cockeysville 13210 Beaver Dam Road 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F Maryland 1930 215-22-3883 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√ No Director Cockeysville Baltimore 10g. Citizen of What Country? 10e. Street and Number USA 21030 13210 Beaver Dame Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white β 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) telephone company 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Emma Augusta Metzbower Charles Edward Marx Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Road Cockeysville, MD 21030 13210 Beaver Dam Sharon Alecci/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ⊠Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Paltimore, MD 21201

23a. Parilt. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) PROSTAGE CANCER Physician /Medical Due to (or as a consequence of): 5 YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a ponsequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached fo ☐Yes 2☐No 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Tes certificate 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To s after deam.

rai Director: After this r 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11/08/2007 MD D78768 elulu 30. Name and address of person who completed use of death (Item 23a) (Type, Print) MD 1650 ORLEAMS ST ROOM IMSI - BACTITIONE, TID ? 1231-1000 A. KIRTONRFILERA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 1 5 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 23:00 NOVEMBER 12, 2007 MARIE ELIZABETH NOCK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🛱 F 15, 1918 Pennsylvania 89 Director 174-12-7577 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2X No Directo Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21040 USA 2420 Greenheart Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Ş Q White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental ! and 2 should be Mary Elizabeth Kubik Stephen Louis Keller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 2420 Greenheart Lane, Edgewood, Maryland 21040 Judi Harris / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 P , o. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 11-16-07 Towson, Maryland 21. Signature of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ardiogeni our /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Ku Eperaton 25. Was case referred to nedical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Tol 2 ER/Outpatient 3 DOA 28d, Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D-18779 November 13, 2007 Sun, W. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) oath (Item 23a) (Type. Print) 17/6 Harford Road, Suite 105, Fallston, MD 21047 M.D.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day,

32: Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36608 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 50 AM ROBERT ONEIL NOVEMBER 09 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOPKINS BAYVIEW MEDICAL 8. Date of Birth (Month, Day, Year)
Sept 17, 1 Number 9. Birthplace (State or Foreign 1**X** M 2□F Months Days Hours Min. 213-84-1957 44 1963 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7730 Charlesmont Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Self Employed Painter Painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter P. O'Neil Mary Helen Weigert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sondra L. O'Neil/wife 7730 Charlesmont Road Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State Chesapeake Crematory 11/13/07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) chonary Due to (or as a conseque ce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner burial-trar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show at notifled Director

23a or must be

items

"natural", or item: edical Examiner n

than "

Ifh and Mental Hygiene. 27 Is marked other than 'r traumatic event, the Me

Department of Health Important: If item 27 any injury or other tr

s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth

Pages 1

Funeral

þ

Completed

Be

filed within 72 hours after death

Maryland 21215-0036

Baltimore,

physician as the l use for page 2 funeral director,

law requires that the death certificate be executed à s been signe should be c has certificate Physician: After this or Attending death. within 24 hours after death To the Funeral Director: Hospital

Division or Vital Records, P.O. Box 68760,

Physician/Medical Examiner Completed by Be Certification: To filled in by Medical completely

State

Registrar

29b. Signature and title of certifier

6 Could not be determined

29c, License number 56466

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Comptell Blvd White Marsh 4924

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year) NOV 15 2007

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

32 Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3:37 AM **Physician** Parnell 12007 06 John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Cita Hospital Good Samaritan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 14, 1960 9. Birthplace (State or Ebreigh Country) unk 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Min. 1₩ 2□F Months Hours 47 212-84-6987 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 10a. State t- Yes 2 □ No Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ral", or items 23a or Examiner must be r USA 21212 600 Bellona Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.Sunk Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: black 1 ☐ Yes 2 ☑ No altimore, Maryland 21215-0036 Specify Be Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", I Hygiene. other than "natura ent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk other unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk of Health and Mental H item 27 Is marked ott r other traumatic even Pages 1 and 2 should be ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6501 Loch Raven Blvd Baltimore, MD Good Samaritan Hopsital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ₹ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Important: If any Injury or once. 4□Donation 5▼Other (Specify) in state 21. Signature of Feneral Servi Licensee Runa L. S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street 23a. Partn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sentic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner preumom Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Due to lo Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, nding p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an has e 2 s autopsy certificate ha 2K No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 2 ER/Outpatient 3 DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Magner of Death 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES 000 PGY-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore. BLVD. LOCH Cul . Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2007 Registrar

DHMH 17 Rev 1/2001

Dou	igias Bla	air Ro		IS St 1- For State Registrar	ate of Maryla		artment o <i>rtificate o</i> :		Mental		Reg. No.		
Me	Phy dical Ex	/sicia	an/	Decedent's Name (First, Middle DOUG)	. ,	D D(	OBERTS			2. Date of De		3 Time of Death 5	
455	aloui Ex	· Carrii	101	4a. Facility Name (if not institution			DEKIS	4b. City, Town, or L	ocation of De		er 12, 2007 4c. County of D		
	-			Howard County Gene	•	7. 0 == (1= :==		Columbia	Tiriti ai		Howard		
	Fune Direc			5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	⁄lin.		oreign	
				060-38-0758 Usual Residence of Decedent	7 W 2 1	62				Uct.1	7,1945	Country) New York	
7		low any		10a. State 10b. County Maryland Anne	Arundel	10c. City	, Town or Locat Pasa					10d. Inside City Limits 1 Yes 2 No	
1	larylan	28a-f show	Director	10e. Street and Number	dilder			10f. Zip Code			10g. Citizen of What		
-	h the N	3a or 2		263 10th Stree	t			21	122		U.S.A		
	eath wit	items 2	Funeral	11. Marital Status  1 Never Married 2 M	arried Armed Fo		I.S. 13. Wa	is Decedent of Hisp es, specify Cuban,	anic Origin? ( Mexican, Pue	Specify Yes or Nerto Rican, etc.)	lo- 14. Race - A White, e	merican Indian, Black, tc.	
	after de	al", or	by Fu		1 Yes  Orced If Yes, Give Year  or Dates:		1 🗆	Yes 2 No	specify:		Specify:	White	
	2 hours	"natur Exam	ted t	15. Decedent's Education (Spec Elementary/Secondary (0-12)	cify only highest grad College (1-		16a. Deceder during m	it's Usual Occupation ost of working life. I	on (Give kind DO NOT use	of work done retired)	16b. Kind of Busine	ess/industry	
	036 ithin 72	r than Acdical	Completed	12	4	-4 O( 3+)	S	ervice Ma	nager		Home E	xpo.	
루 프로토리 (A)													
	212 ould be	s mark ic even	To Be	John F. R  19a. Informant's Name/Relations			19b. Mailin	g Address (Street		vian or Rural Route No	Cockre11 umber, City or Town, S	State, Zip Code)	
	and 2 should lealth and Me	em 27 l		Deborah A. Ro	berts (W	ife)					, Maryland		
	Baltimore, permit. Pages 1 a Department of He	other t		1 Burial 2 Cremation	3 Removal fro	m State	crematory or ot			Date	20c. Location - Cit		
	altin mit. Pa partmer	portan ury or	ł	4 Donation 5 Other Sp. 21. Signature of Funeral Service			. /	Crematory		-15-07	l l	e, Maryland	
			4	- King J	11/2	M	/ Mg	204 <sup>1</sup> Mount	yniak ain Ro	Funeral ad, Pasa	Home P.A. Idena, Mar	yland 21122	
,	Physic /Medi	ical		23a. Port I. Enter the disease, or ailure. List only one cause	on each line.					c or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death	
	⁻xami≀	ner	4	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic caridiovascular disease  Due to (or as a consequence of):									
			Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence o	of):						
	H	X	Examiner	Comparison of the control of the con									
	ecuted	and transit	E E	d.									
	68760, certificate be executed	hysician and be burial - transit	Medical	X UNPENDED			73, 11/19	/07 TT			1		
	6876 erifical	ding ph	$\sim$ 1	23b. Was decedent pregnant in the past 12 months?	e 1 Live bi		<sub>2</sub> Fe	tal death 3	Ectopic pre	gnancy	23d. Date of del Month	ivery Day Year	
	Box death c	d for s	ysic	1 Yes 2 No 9 Unk	nown 9 Unknow	int at time of de wn	eath 5 Ot	her (Specify)			2007		
	that the	ned by the attending ph detached for se -s the	by Phy	Part II. Other significant conditi	ons contributing to	death but not r	esulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?	
	ds, F	een sigr	ited							1Y		Probably 4 Unknown e autopsy findings available	
	e law r	te has b ge 2 sh	Completed					·		auto perf	ppsy prior deat	r to completion of cause of th?	
	al R	ctor, pa	υl	25. Was case referred to medical examiner?					of Death (Che		2 No 1	Yes 2 No	
	of Vit	The part of the pa									Other:		
	ON Constant	or: Att	Certification:	1 X Natural 5 Pend		Day,Year)	Zob. Time of t		s 2 No	200. Describe	s now injury occurred		
	ivisi or Att	Jin by	Iii	3 Suicide 6 Could	not be	of Injury - At h	ome, farm, stree	et, factory, office bui	lding, etc.	28f. Location or Town,		r Rural Route Number, City	
	D lospital	unera		29a. Certifier	mined (Specify)	of my knowled	ac death ecour						
	Division of Vital Records, P.O. Box 6870 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.	o the r	10	CHOCK Only		examination a					use(s) and manner as e and place, and due		
_			ž	29b. Signature and title of certifier				29c. License				(Month, Day, Year)	
J				30. Name an address of rerson	MAN completed cause	of death (Item	(23a)	O.C.M	.c.		November 13	, 2007	
	10			Pamela E. Southall, M	•	•	-	1 Penn Street,	Baltimore	MD 21201			
	Re	Sta	ate rar	31. Date filed (Mdd 1, 114y, Year)		istrar's Signati	ite	les !					
				<del></del>			- 4						

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician Μ. Resch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Elder Care Severna Park If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2XF Director 219-05-0818 Usual Residence of Decedent 10b. County 10c. City, Town or Location Director Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 21061 7830 Oakwood Road

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760,

this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-transi within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

runer	11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 K No	. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et	or No-	14. Race - Ame Black, White	e, etc.
	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2Ã No	Specify:		Specify: W	hite
Completed by	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b. K	ind of Business/	Industry
Ē	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner	u)	Ele	ctric C	ompany
	17. Father's Name (First, Middle, Last)	)		18. Mother's Name (First, A	Aiddle, Maider	Surname)	
o Re	Matthew Muller			Christina Ka	auten		
_	19a. Informant's Name/Relationship (	Type. Print)	19b. Mailing Address (Stree	t and Number or Rural Route	Number, City	or Town, State, 2	Zip Code)
	Charlotte Maiste/			y Road Crowns			
	20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	ace of Disposition (Name of metery, crematory or other pla en Haven Mem.	Park 2007		ocation - City or .en Burn	
	21. Signature of Funeral Service Licer	nsee	22. Name and Addr	ess of Facility Singlet	ton Fur	eral &	Cremation
	Clendle	WC M014-		1 Second Avenu		Glen Bur	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.			atory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	а	Al Zheimi	Devoto			140
	resulting in death)	Due to (or as a consequ	ence of):				_
_	Sequentially list conditions,	b. — Bus to for so a concession	ana of:				
II I	if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequ	ence oi).				
хад	that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):				
E E		240 10 (0. 22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2					
ğ		▲d					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome pf pregnal 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 ☐ Ectopic pregnan			23d. Date of de Month	olivery Day Year
F	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying cause g	iven in Part I. 236	e. Did tobacco	use contribute t	o the cause of death?
d b					1 ☐ Yes	2 <b>/21</b> No 3□P	robably 4 □Unknown
ete				248	a. Was an	24b. Were a	utopsy findings available
ᇤ					autopsy performed?	death?	
္သ	25. Was case referred to medical	T		26. Place of Death (Check	Yes 22 N	lo 1 ☐ Ye	S 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Be	examiner?	Hospital: 1   Inpatient 2	ER/Outpatient 3 DOA O	ther: Nursing Home 5[		6 □Other (Soc	ecify)
ication: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inj		scribe how inj		
ğ	Natural 5 ☐ Pending 2 ☐ Accident investigation	1 1		JYes 2 No			
	3 ☐ Suicide 6 ☐ Could not b	28e. Place of injury - At ho building, etc. (Specify	me, farm, street, factory, office		ation (Street a or Town, Sta		Rural Route Number,
Medical Certii	29a. Certifier Certifying P	hysician: To the best of my kno	wledge, death occurred at the	time, date and place, and due	to the cause	(s) and manner a	as stated.
dica	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	tion and/or investigation, in my	opinion, death occurred at th	e time, date a	nd place, and du	ue to the cause(s)
Ze	29b. Signature and title of certifier			nse number	29d. D	ate signed (Mor	nth, Day, Year)
				137036		11/13/2	,00/
	30. Name and address of person with	completed cause of death (Item	23a) (Type, Print)	. 0		A . A .	1116
	(say 1 )	pruse 2	23a) (Type, Print) 1) on	on live	Challe	(, ,,,,)	71617
te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture				
ar	NOV 1 5 2	007 Segue L	foods				

2. Date of Death

November

8. Date of Birth (Month, Day, Year)
Feb. 23,1922

10,2007

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian,

U.S.A.

Anne Arundel

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

1 □Yes 2 No

DHMH 17 Rev 1/2001

Sta Registr

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36612 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 13, 2007 11:06 AM MILTON J. SZYMANSKI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 212 KING GEORGE DR. GLEN BURNIE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months 1XM 2□ F Yrs. MARYLAND 27, 1930 Director FEB. 220-24-0138 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 😿 No Director ANNE ARUNDEL MARYLAND GLEN BURNIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 21061 212 KING GEORGE DR. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🔯 No Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSIDE SALES REP SALES 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GENNIE WOZNIEWICZ 2 ALEXANDER SZYMANSKI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLEN BURNIE, MD 212 KING GEORGE DR. GERALDINE SZYMANSKI / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 17 2007 NOV. 4 □ Ponation 5 □ Other (Specify) HOLY CROSS CEMETERY BROOKLYN PARK, MARYLANI ture of Fun ral Service Do 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 0 GLEN BURNIE, MD 21061 421 CRAIN HWY. SE; 23a. Part I Pinter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MYELODYSPLASTIC SYNDROME 5 years **Physician** /Medical Due to (or as a consequence of): **Examiner** month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ MALNUTRITION 1 Yes 2 No 3 Probably 4 Unknown Completed CARDIOVASCULAR DISTASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 57480 Juana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1VANA GOID 22 SOUTH GREENE STREET, BALTIMORE, MD 21201 6010 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 5 2007

DHMH 17 Rev 1/2001

Registrar

State Registrar and title of certifier

30. Name and address of person who completed

NOV 1

29b. Signatus

1Don and

Date filed (Month, Day, Year)

within 24

cause of death (Item 23a) (Type, Print)

Redistrar's Signature

29d. Date signed Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepe, 1- For Amend 10b, perFH, 26 per MD, 0873, 11015/07 The of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Pay **Physician** Nov. 2007 11:00 P M Mary C. Sauer /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll 2319 Sandel Lane Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours 1□ M 2□ F 88 218-03-2760 26 1919 MD Aug. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No MD Timonium Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 USA 7 Teaneck Ct. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2(X) No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 27 No white Baltimore, Maryland 21215-0036 Specify Specify: Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Religious Secretary/Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Elizabeth Webb William Edrington 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Teaneck Ct., Timonium, MD 21093 Carroll F. Sauer/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Xurial 2 ☐ Cremation 3 ARemoval f State 11/13/07 Woodlawn, MD Lorraine Park Cemetery 4 AD nation 5 ☐ Other (570cify)/ Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. gn y er sevice i ensee Bryan W. Clary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastutic Physician Holeur Carcin C Mg /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, learny, hearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 TYes certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 6 Pauchter's Residence Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Datural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2973 Manchester Rd., Manchester, MD 21101 M.D. Herbert Henderson, Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 13, 2007 **Physician** 4:30 A. M Marion M. Streett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Ruxton Health & Rehab Center Pikesville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days Months 1 M 2 X F 80 220-20-1392 Director May 29, 1927 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 49 Millstone Road 21133 United States of America by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 Hygiene. "her than "n. the Me." Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home and Mental Hygins is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Williams Viola Marcella Cullison other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Debra Lynn Brugh (Daughter) 49 Millstone Road, Randallstown, Maryland item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Pk 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 11/16/07 Sykesville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 M0033 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Paper. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the SS If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? detached for 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes ours after death.

eral Director: After this certification in by the funeral director. Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 | Inpatient Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3□ DOA 1 Tyes 2 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: (Month, Day Year) Injury 5 | Pending 1 Yes 2 No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6565 N. Charles St Suite auknorMD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

5

NOV 1

4:30Am

13/

onald	K Simkir		State of Maryland / Department of 1-For State Certificate of Registrar			.No. 200	7 3661					
	Physici	an/	Decedent's Name (First, Middle,Last)		2. Date of Death Month November		3. Time of Death 0630 hrs					
/ledica	al Exami	ner	RONALD K. SIMKINS  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		13, 2007 4c. County of Death						
	•		Sinai Hospital	Baltimore		BALTIMORE	CITY					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	(MM/DD/YYYY) 9. Birth Foreign						
I	Director		216-88-2631 1XM 2 F 46 Y			1, 1961 <sup>Cou</sup>	<sup>ntry)</sup> MARYLAND					
	, i		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Local	ation			10d. Inside City Limits					
	nd how a		MARYLAND ANNE ARUNDEL GLEN BURN	ਜ਼ਾਜ			1 Yes 2 X No					
-	daryland 28a-f show any 1 at once.	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Count	ry?					
$\equiv$	3a or ;		722 STAFFORD HILL DR.	21061		UNITED STAT						
	be filed within 72 hours after death with the Maryland ntal Hygiene	Funeral	1 Never Married 2 Married Armed Forces? If	as Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,					
	ter dea		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: WHI	TE					
	atural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	ent's Usual Occupation (Give kind of most of working life. DO NOT use ret		16b. Kind of Business/In						
ထွ	n 72 h an "n ical Ex	omplete	Elementary/Secondary (0-12) College (1-4 or 5+)	· ·	iled)							
93	filed within Hygiene. d other th	E O	12 WAREH	OUSE WORKER	e (First, Middle, M	DISTRIBUTI aiden Surname)	NG					
21215-0036	Id be filed within 72 hours after Aental Hygiene. narked other than "natural", event, the Medical Examiner	Be C	JEREMIAH KEITH SIMKINS		LUCILLE							
_	6 2 5 5			ng Address (Street and Number or								
A	nd 2 st alth an em 27 rauma		, ======	STAFFORD HILL DR	Date	BURNIE, MD 20c. Location - City or	21061 own. State					
Baltimore,	permit. Pages 1 and 2 shoul Department of Health and M Important; If item 27 is m injury or other traumatic.		1 X Burial 2 Cremation 3 Removal from State crematory or	other place) NOV	. 16,							
Ei.	nit. Pa artmen ortant ry or o		21 Signature of Eugeral Service Licensee 22	DGE MEM. PARK  Name and Address of Facility	2007	ELKRIDGE, I	MARYLAND					
Ba	Dep Imp		Edward Lynn 4	IRKLEY-RUDDICK FO 21 CRAIN HWY. SE	GLEN I	BURNIE, MD	21061					
	nysician Medical		23a. Part I. Enter the disease, of complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and					
	taminer		Immediate Cause (Final disease or condition resulting in death)  a. End stace renal discussions of the condition resulting in death)  Due to (or as a consequence of):				Death					
			Sequentially list conditions, b									
		iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause									
	uted Id ransit	Examiner										
	ite be executed nysician and burial - transit	Physician/Medical	X UNPENDED AMENDED #23a, PII, 27, perME, 2873.	11/19/07 TT								
68760,	certificate be nding physici ise as the buri	n/Me	23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregn	ancy	23d. Date of delivery  Month D	ay Year					
39 ×	eath certificate attending phy for use as the	icia	past 12 months?  4 Pregnant at time of death	Other (Specify)								
Вох	the death by the att	Phys	Part II. Other significant conditions contributing to death but not resulting in the	a underlying cause given in Part I.	23e. Did tot	pacco use contribute to t	he cause of death?					
P.O.	that ned deta		Hypertensive atherosclerotic cardiovascular		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown					
rds,	v requires tha s been signed should be det	ete			24a. Was a		opsy findings available ompletion of cause of					
of Vital Records,	2 13	Completed by			perform 1 ✓ Yes 2	med? death?						
a R	ian: The certificate ector, page	Be	25. Was case referred to medical	26.Place of Death (Check	only one)							
Vit	hysik this 1 dir		examiner?  Hospital: 1 Inpatient 2 FR/Outpatie			Residence 6 Other Ow injury occurred						
		ion:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Death	1 Yes 2 No	Zou. Describe ii	ow injury occurred						
Division	r Atter er dear irector n by th	ertification:	2 Accident Investigation 28e, Place of Injury - At home, farm, str	eet, factory, office building, etc.		treet and Number or Ru	al Route Number, City					
á	ospital or At hours after d meral Direct y filled in by	Certi	4 Homicide determined (Specify)		or Town, St	ate)						
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical (	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investige and manner stated.	surred at the time, date and place, an pation, in my opinion, death occurred	d due to the cause at the time, date a	e(s) and manner as state and place, and due to the	d. e cause(s)					
	<b>T</b> ⊗ 10 00 00 00 00 00 00 00 00 00 00 00 00	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	th, Day, Year)					
			Carol Hallan	O.C.M.E.		November 13, 20	07					
			Name and address of person who completed cause of death (Item 23a)     Carol Allan, MD	Street, Baltimore, MD 2120	01							
	S	tate	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	ack)								
	Regis											

**ORIGINAL** 

# Brint in Black Indelible Ink Ensure All Copies Are Legible.

07-08//1	∞ ith	State of Maryland / Department of Health and M	Mental Hygie	ne	·	
Carlos Eugene Sr		For State Control of Theath and Williams Certificate of Death	10111.01.1199.01	Reg. No	200	7 36617
Dhyaiaia	R	egistrar I. Decedent's Name (First, Middle,Last)	2. Da	te of Death		3. Time of Death
Physicia Medical Examin		Carlos Eugene Smithson	No	onth Day vember 11,		1800 hrs
Rite.		ia . Facility Name (if not institution, give street and number)  4b. City, Town, or Local	ation of Death		4c. County of Death	1
C)		Johns Hopkins Hospital Baltimore			NIA	
Funeral		Social Security Number 10.36x 11.795 (11.75)			M/DD/YYYY) 9. Bir Foreig	
Director	- 1.	220-08-79/3 15M 2 F 22 Yrs. Months Days	J.	ine 24,	1985 co	puntry) Maryland
	t	Usual Residence of Decedent				10d. Inside City Limits
v any		10a. State 10b. County 10c. City, Town or Location Bryland N/A Baltimore				1 Kes 2 No
and shov	اة	400 75- 0-4-		100.0	Citizen of What Cou	intry?
death with the Maryland or items 23s or 28s-f show must be notified at once.	Director	10e. Street and Number	2 / 4	11	1-1-01	1.6
3a or		433 North Robinson Street 2122		Voc or No-	1 14 Race - Ame	rican Indian, Black,
h with	era	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispani If Yes, specify Cuban, Me	exican, Puerto Ricar	n, etc.)	White, etc.	
r deat or ite	Funeral	Yes 27 No	pecify:		Specify: B	lack
2 hours afte "natural",   Examiner	<u>a</u>	3 Widowed 4 Divorced if Yes, Give Year 1 Yes 22 No Sp.  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 1		ione 16b	b. Kind of Business	/Industry
hour "nate	te d	during most of working life. DO	NOT use retired)		Mc Dena	ld S
36 thin 72 than than		12 Clerk		1	restaur	-ant
5-0036 iled within 77 Hygiene 1 other than	Completed	17. Father's Name (First, Middle, Last) 18.N	Mother's Name (Firs			
215 se file ntal H.	Be (	EMM BILL	averno		ithson	Tin Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print )		Route Number	, City or Town, Star	e, Zip Code)
MD 12 sh th and th and th and unmat		OHIF IES OF Z	ery Dat	1 Pai	Oc. Location - City of	MD 2/229 or Town, State
Te, I and I heal		1 Removal from State crematory or other place)			_	\
MOI Pages ent of int: 1		1 Donation 5 Other Specify 1	m. Nov. 17		Ranca	rore, MD
altil mit. partm porta ury o		21. Signature of Funeral Service Licensee 22 Name and Address of	FacilityWiLU	Ams H	_	ERVICE, PA
E E E		Calvin I. Withans 120 Free	d hilton	Parss piratony arrest	Balton shock or heart	Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	cri as caldiac of res	piratory urrest,	onoski o moski	Between Onset and Death
xaminer	F N	Immediate Cause (Final disease a. Gunshot Wound of Torso and Right Arm				-
k Kammer		or condition resulting in death)  Due to (or as a consequence of):				
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	Cause. Enter Underlying Cause C.				4
νχ = ·Ξ	xar	events resulting in death) Last Due to (or as a consequence of):				
executed ian and ial - transit	ical E	d				
<b>),</b> be ex sician	ğ	UNPENDED			23d. Date of deliv	ery
i, P.O. Box 68760, ires that the death certificate be signed by the attending physicil to be detached for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		Month	Day Year
certil certil	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
Box e death c the atten	ysi	1 Yes 2 No 9 Unknown 9 Unknown		oo Didaha	ann una contribute	to the cause of death?
O. at the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.			robably 4 Unknown
, P.O.	b b			24a. Was an		autopsy findings available
ords, w requir s been s	활			autopsy	prior t	to completion of cause of
Recol The law	Completed			1 Yes 2		
tal Rectinan: The	ပြိ	25. Was case referred to medical 26.Place o	of Death (Check only	one)		
Vita hysicia this cer	00	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	other Nursing H			ther:
of Vital Records, ing Physician: The law requir. After this certificate has been s funeral director, page 2 should 1	۽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	- Isu	d. Describe ho ibject shot	w injury occurred	
ION tendin eath.	흘	J Felicity	es 2 V No	•		The state of the s
Division tal or Attendir rs after death.	🖺	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bui		or Town Sta	te)	Rural Route Number, City
Div oital o ours af	Certification:	determined (Specify) Single Family Home	1000		venue, Baltimore	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, of	e and place, and du- death occurred at th	e to the cause( ne time, date ar	<li>s) and manner as s id place, and due t</li>	stated. o the cause(s)
o the orthin onple	Medical	and manner stated.			29d. Date signed (	
- > - >	Ž	29b. Signature and title of certifier  O.C.M			November 12,	
		( Latertistella)	····			
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD Assistant Medical Examiner 111 Penn Street, Baltim	ore MD 21201			
<i>~</i>		Early Edoke W.D. Teddetare	1016, IVID 21201			
	State					
Regi	अस्ति	110 / 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 6:10 P M Stewart ames 11 06 7007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore ot Maryland Medical Center if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**∑**M 2□F Maryland 215-70-4651 47 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1√ Yes 2 No ? Is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1010 W. Baltimore Street #217 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. Completed by 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) transportation cab driver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Brackett William Stewart ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a Important: If Item 27 is any injury or other trau 1010 W. Baltimore Street #217 Baltimore, MD 21223 James Stewart Jr/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 5₩Other (Specify) in state 4 □ Donation 21. Signature of Eurorel Service Ronald ice Licensee S. Wade, State Anatomy Board 655 W. Baltimore Street Director Baltimore, 21201 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner ORDNAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 1 ☐ Yes 2 No 3 🖺 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No perform funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Yes 1 Inpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, ne Hospital or Attending Pl n 24 hours after death. The Funeral Director: After the To the I within 2 To the I

> State Registrar

completely

Medical

31. Date filed (Month, Day,

5

29b. Signature and title of certifie

29a. Certifier

(Check only

1ALC

32. Registrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

HANDVER

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland  State Registrar	Certificate of Death	Reg. No.2007 36619
	Physicia /Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Date of Death Month Day Year  4c. County of Death
	Funeral Director		Joseph Richey Hospice  5. Social Security Number $453-58-2807$ 6. Sex $1 \times M$ $2 \square F$ 7. Age (In yrs. left)  67	Months Days Hours Min.	Date of Birth (Month, Day, Year)  Aar 29, 1940  9. Birthplace (State or Foreign Country)  Texas
	he Maryland 8a-f show otified at	Director	MD Baltimore	Town or Location  Baltimore  10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country?
yiang 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at ance.	To Be Completed by Funeral Dir	10. Street and Number  7317 Cantwell Road  11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last)	21244  5.	y Yes or No- an, etc.)  14. Race - American Indian, Black, White, etc.  Specify: black  16b. Kind of Business/Industry  healthcare  First, Middle, Maiden Surname)  unk
Danimore, Mary	permit. Pages 1 and 2 sho Department of Health and I Important: If item 27 is ma any injury or other trauma once.		19a. Informant's Name/Relationship (Type. Print)  Edward Sanders Jr/son  20a. Method of Disposition  1□ Burial 2□ Cremation 3□ Removal from State  4□ Donation 5☑ Other (Specify) in state  21. Signature of Funeral Service Licensee Ronald 5. Wade, Director	19b. Mailing Address (Street and Number or Rural R.  7317 Cantwell Road Balt ace of Disposition (Name of metery, crematory or other place)  22. Name and Address of Facility State Anatomy Board 6  Baltimore, MD 21201	imore, MD 21244
on,	tificate be executed  By Medical  By Medic	I Examiner	a. P.v.1. Enter the seas or complications that caused the death shick, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequence o	Do not enter the mode of dying, such as cardiac or re  CA  W  ence of):  and  ence of):	Onset and Death
J. BOX 00/0U,	e death certificate the attending physi ned for use as the I	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year
ras, r.	The law requires that the death cerate has been signed by the attendir page 2 should be detached for use	۵	Part II. Other significant conditions contributing to death but not resu	lting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
vital necords	in: The law re ificate has bee or, page 2 sho	<b>Completed</b>	25. Was case referred to medical	26. Place of Death (C	24a. Was an autopsy performed?  1 Yes 2 No
DIVISION OF VE	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Certification: To Be	examiner?  1  Yes 2	## Comparison   Co	5 Residence 6 Other (Specify) 101010.  d. Describe how injury occurred  1. Location (Street and Number or Rural Route Number, City or Town, State)
ב	e Hospital o	Medical Cer	29a. Certifier (Check only one)  Certifying Physician: To the best of my know and manner stated.	wledge, death occurred at the time, date and place, and ion and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.  I at the time, date and place, and due to the cause(s)
)	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number + 0 0 64 267	29d. Date signed (Month, Day, Year)  11 - 12 - 07
			30. Name and address of person who completed cause of death (Item  Or William Carlina - Black Hooth Carl Year)	aun 827 Linden	M. Coltunae, MD. 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signa NOV 1 5 2007	Specter	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:45 AM Thomas Gilbert 0. November 12, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Rosedale 5459 Princess Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 XM 2 ☐ F 219-30-2520 75 Maryland 13,1932 Director April Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □Yes 2x No Director Rosedale Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 2 should be filed within 72 hours after death with and Mental Hyglene.

Is marked other than "natural", or items 23a or " United States 21237 5459 Princess Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc 1 Nes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ANO Specify. 2 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 12 Years Steelworker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Palma Webster Orville B. Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is many injury or other one. Mrs. Dolores A. Thomas 5459 Princess Drive Baltimore, Maryland (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-15-2007 Gdns of Faith Cem. Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Sign were of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 months Physician /Medical Due to (or a a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2**X** No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 TYes 2 🗌 No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours after
To the Funeral Dire
completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 024356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 2200 Baltimore, maryland Orive Suite 32. Registrar's Signature 9103 Franklin 1 5 2007 State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November<sup>™</sup>, 2007 **Physician** 8:25 а м Velevis Lena Μ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Mariner-Overlea Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral**  $\frac{Y_{ear}}{1917}$  Mary Tand Sept 17, Months Days Hours 1 □ M 2 📝 F 90 215-01-0021 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10b. County 10a. State 23a or 28a-f show the Medical Examiner must be notified at Y∏Yes 2 No Director Baltimore MD n/a 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U.S.A. 5225 Todd Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify þ White 3 X Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other thar any Injury or other traumatic event, <u>the M</u> Button hole maker Tailor shop 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Coppolino Domenica Coppolino Paul ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna Smith-sister 5225 Todd Ave., Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Locetion - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/07 Overlea, MD Gardens of Faith 4 Donation 5 Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, 21. Signature of Funeral Service Licensee William G. Dau 5305 Harford Rd. Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 pronths?
1 ☐ Yes 25 ☐ No 3 ☐ Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the lying cause given in Part I. ģ 1 ☐ Yes 2 □ No 3 Probably Be Completed 24b. Were autopsy findings evailable prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes IZ No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only onle) 2 Other: 4 Sursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Tes 1 Inpatient 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No **Director:** filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Itle Date filed (Month, Day, Year) 32 Registrar's Signature State 5 2007 Registrar

State of Maryland / Department of Health and Mental Hygien & UU / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 12:55 PM GENEVIEVE JULIA WOODEN November 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health & REhabilitation Ctr. GlenBurnie Anne Arundel 8. Date of Birth June 14, 1920 5. Social Security Number 212-09-8269 If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🛣 F 87 Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at Marvland Anne Arundel Baltimore [ ] 1 ☐ Yes 2 No Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5714 Moore Street 21225 USA "natural", or items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumate. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife & Mother Domestic Engineer 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Petruszewski Helen Kucz (SON) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christian Kenneth Wooden, Jr. 5808 Park Road, Baltimore, Md. 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery Baltimore, Maryland 11/14/2007 21. Signature of Furneral Service Licensee Kevin E Ecker gersighiak Funeral Home, P.A. Patapsco Ave., Balto., Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed burial-transit gg/ P.O. Box 68760, physiclan Physician/Medicai as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregpant 3 Ectopic pregnancy 00 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4☐Pregnant at time of death 5 Other (specify) ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 🖪 No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes Division of Vital 2 1 No 1 🗌 Yes Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one. examiner Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death.
I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state(). (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie LINGHUG SRAP 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO 0 Tel Date filed (Month, Day, Year) 32 Registrar's Signature NOV 15 2007 naule Registrar

			1 - For State Registrar	State of Maryland / Department of Health and Mental Hygien OCertificate of Death	7 36623
	Physici /Medic		1. Decedent's Name (First, Middle, L Sharen	Ann Winde Nov 13 20	
*	Examir	ier	4a. Facility Name (If not institution, gastern form)  5. Social Security Number 6.	ity General Hospital Columbia Hor	ward
ŀ	Funeral Director		219-94-7505 Usual Residence of Decedent	1 M 2 F 42 Yrs. Months Days Hours Min. 7-25-965	9. Birthplace (State or Foreign Country)
	e Marylan Ba-f show	Director	10a. State 10b. County	Baltimore	10d. Inside City Limits 1 Syres 2 □ No
	ath with th	ral Dire	6811 Townbroo		SA
9003	72 hours after death with the Maryland neturel', or Items 23e or 28a-f show iteal Exama we must be porfibed at	d by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced		- American Indian, , White, etc. White
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "neturel", or Items 23e or 28a-f show other then "neturel", or Items 23e or 28a-f show event, the Medical Exertit or must be a willing at	Completed	15. Decedent's (Specify only highest g	College (1-4or 5+)  Colleg	iness/Industry a Leigh Spital
Maryland	should ba fill nd Mental His markad oth	To Be	Donald Fur	Charlotte	) <b>'</b>
-	ges 1 and 2 should t of Health and Mer If item 27 Is marks or other traumatic		Shanon Hall	Daughter) 6250 Sandrise Ct. Apt 304, ElKrid	ge, MD21075
<b>Baltimore</b> ,	t. Pa rtmen rtant: rjury		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spec	Removal from State King Nemorial Fark 11/17/2007 Baltin	nove, MD
Bal	parmi Depa Impo		21. Signatur of Funeral Service Lice	22. The and Address of Fastive ene, Funeral Se 515 Bulto. Natil File, Batto., In polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	ND 21229
	Pnysician /Medical		shock, or heaft failure. List only Immediate Cause (Final disease or condition resulting in death)	a. rend failure	Approximate Interval Between Onset and Death
	Examiner	er.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):  b. Due to (or as a consequence of):	years
j.	icate be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
68760,	tificate be ng physicia as the bur			d	
.O. Box	that the death certificate ed by the attending phys detached for usa as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23d. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  9 Unknown	of delivery th Day Year
<u>α</u>	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib	oute to the cause of death?  B Probably 4 Unknown
Vital Records,	(0 ==	Completed		autopsy pr performed? de 1 ☐ Yes 2 No 1 [	ere autopsy findings available ior to completion of cause of sath?
of Vit	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death	Hospital: 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurre	
Division	To the Hospitel or Attending Physician: whithin 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	Accident  3 Suicide 4 Homicide  5 Pending investigation of Could not determined	(Month, Day Year) Injury Work?  M 1 Yes 2 No	
٦	To the Hospitel or within 24 hours afte To the Funerel Dir. completely filled in	edical Ce	29a. Certifier (Check only one)  Certifying P  Certifying P  Check only one)	hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, an and manner stated.	ner as stated. nd due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed 29c. License number 29d. Date signed Nov	(Month, Day, Year)
	3		KENDR		21043
8.0	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 200	7 Registrar's Signature	

			1 - For State of Registrar	-	artment of H	ealth and Mental I Death	Hygiene 007	36624
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date o	mber 12, 200	3. Time of Death 7 10:10 AM
	/Medio		William H. Woods  4a. Facility Name (If not institution, give street and num	ber)	4b. City, Town, or	Location of Death	4c. County of Dea	
1	Lxaiiii	161	Glen Meadows Health Ce	nter	Glen A		Baltimo	re
	Funeral Director		219-05-4975 <sup>1∑M 2□F</sup>	'. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	Hours Min. 8. Date of (Month)	f Birth (9. Birth (20, 1919 Mail	rthplace (State or Foreign country) cyland
	ow a		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	a-fsh	ctor	MD Baltimore	Glen A	Arm			1 □ Yes 2 No
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code	1057	10g. Citizen of What C	ountry?
	leath v	erai	11630 Glen Arm Road  11. Marital Status 12. Was Dece	dent Ever in U.S. 13.				erican Indian,
21215-0036	within 72 hours after death with the Maryland she. than "natural", or items 23e or 28e-f show the Modell Examiner must be notified at	by Fun	Armed For 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 1 Never Never Or Day	2 No	If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Specify Yes on in, Mexican, Puerto Rican, etc Specify:	.) Black, Wh	
2-0	72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation during most of working ()	16b. Kind of Busines	s/Industry
121	within ane. than	idmo	Elementary/Secondary (0-12) College (1-12)	4or 5+)	<i>DO NOT use retired</i> k maker	"	munitions	
d 2	ill Hygiene. other thai	a	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Mi		
ylar	should be and Mental is marked o	To B	Joseph Woods			Nellie Bar		
, Maryland	1 and 2 sho Health and i em 27 is mu		19a. Informant's Name/Relationship (Type, Print) Karen Friedlander/guardi		ng Address (Street a Ashlee Co	and Number or Rural Route Noute N	umber, City or Town, State, om, PA 17349	Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, If a Michael Examiner must be notified at ODGs.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from 5 1 ★ ☑ Donation 5 □ Other (Specify)	tate	osition (Name of matory or other plac	Date	20c. Location - City o	r Town, State
Balt	permit. Departinoporti		21. Signature of Funeral Service Licensee Ronald S. Wade. D	irector Si		omy Board 655  MD 21201	W. Baltimore	Street
1760,	Physician // // // // // // // // // // // // //	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence of):	Cardia Cardia	K i	LL Childre	Approximate Interval Between Onset and Dear  3 W  10 Y
P.O. Box 68	nding pluse as t	Physician/Medi	in the past 12 months?	ant at time of death 5[	□Ectopic pregnancy	,	23d. Date of d Month	elivery Day Year
	juires that the death n signed by the atte	þ	Part II. Other significant conditions contributing to de	athybut not resulting in the u	underlying cause giv	all tus	Did tobacco use contribute	to the cause of death?
I Records,	The law requir ate has been si page 2 should	Completed	Dementia Leni	le: Hyp	ma		Was an autopsy prior to death?	
Vital	Physician: Th this certificate rai director, pag	Be	25. Was case referred to medical examiner?		Oth	26. Place of Death (Check of		
of	Phys this rai di	tion: To	To tes 2/2000	patient 2 ER/Outpatie f Injury g, Day Year) 28b. Time of Injury	of 28c. Injur	ursing Home 5	Residence 6 Other (Sp ribe how injury occurred	ecify)
Division	el or Attendi s after death. Il Director: A id in by the fi	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home, farm, st g, etc. (Specify)	reet, factory, office		ion (Street and Number or a or Town, State)	Rural Route Number,
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune.	Medical C	29a. Certifier Check only one) Certifying Physician: To the band manner: On the band m	sis of examination and/or in	th occurred at the tin	ne, date and place, and due to pinion, death occurred at the	o the cause(s) and manner time, date and place, and d	as stated. ue to the cause(s)
)	To the vithin To the comple	W	256. Signature and title of certifier	= Acar mo	29c. Licens	e number	29d. Date signed (Mo	nth, Day, Year)
		)	30 Mayne and address of person who completed caus	ofdeath (Ipem 22a) (Type	Print)	c (post ROA	25 \$ 159 m	BACTMORB 21228
	Sta Regist		31. Date filed (Month, Day, Year) 22. R	gistrar's Signature	de			

			Please '	Type or Print in E State of Marylan								_	06605
			For State Registrar	Otate of Marytan			te of L		2110 1410		Reg. No.	200/	36625
	Dhomisi		Decedent's Name (First, Middle, Las.		1 -					2. Date of De. Month		Year	3. Time of Death
	Physici /Medic		Vernon And	110.0	itts, S	1				YOVEMB	SR 13	2007	
1	Examin			OFBALTIMO		31	ALTI	MOR (	e c	LTY		County of Dea	J/A
	Funeral Director		5. Social Security Number 6. Sec. 212 · 28 · 0475 1/2 Usual Residence of Decedent	THE OFF	(Ast birthday) Yrs.	Months	er 1 Year Days	If Under Hours	Min.	8. Date of Bin (Month, Da	1193	9. Bir	thplace (State or Foreign puntry)
	Maryland	tor	10a. State 10b. County  MD Battar		Pike	SVII	e)						10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23s or 28 ust be no	Funeral Director	10e. Street and Number 4724 Duncai	mon Road	d	10f. Z	ip Code	208			10g. Citiz	en of What Co	ountry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heelth and Mentel Hygiene. Ifem 27 is marked other then "natural", or itams 23s or 28s-f ehow other traumatic event, the Madical Examiner must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1√20'es 2 □ No If Yes, Give Year or Dates:		Was Dec If Yes, sp 1 ☐ Yes	ecify Cuba	spanic Ori n, Mexican Specify:	gin? (Spec n, Puerto P	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whi	
215-0036	within 72 hou ene. then "natura he Madical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	life.	kind of v DO NOT	rork done d use retired	luring mosi )	t of workin	g		d of Business	
7	filed within Hygiene. Ither then then then then then then then then		12th Grade  17. Father's Name First, Middle, Last)	NJA	MI	inte	enan		ar's Name	(First, Middle,		nte of	- MID
Maryland	d Menter marked o	To Be	Joseph Watts 19a. Inform nt's Name/Relationship (7	voe Print)	19h Maili	na Addre	ss (Street	Ger	neva	- Hu	ghes		Zin Code)
	es 1 and 2 sho of Heelth and 7 item 27 is my r other traums		Mary J. Watts	Wife	472	4.		Canr		Rd.	Pikes	ville	MD 21208
Baltimore,	permit. Pages 1 a Department of He important: If item ony injury or oth		20a. Method of Disposition  1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, creations MSOM	sition (N matory or To	ame of other place	θ)	11/19	1 07	ONU		JINS IMD
Balt	permit. Depart import eny inj		21. Signature of Funeral Service Licens	Ü	22	2. Name	and Addres	s of Facilit	v Va Road			eede F	wheral svcs
			23a. Part1. Ententhe disease, or comp shock, or heart failure. List only	lications that caused the deat	h. Do not en	ter the m	ode of dyin					2 110	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. MCTASTAT  Due to (or as a consequence)		ARY	nge	AL	CAR	CINO	nA_		Onset and Death
	ted nslt	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq		M_			_				25 days.
760%	sicien and burial-tra	al Examin	that initiated events resulting in death) Last	Due to (or as a conseq	quence of):								
68760	rtificate ng phy as the	Medic	IF FEMALE:										
P.O. Box	w requires that the daath certificate be executed been signed by the attending physicien and should be deteched for use as tha burial-transit	Completed by Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	⊒Ectopic ⊒ Other (	pregnancy specify)				2	3d. Date of de Month	olivery Day Year
	requires that the een signed by th hould be deteche	y Ph	Part II. Other significant conditions co	ntributing to death but not res	sulting in the u	ınderlying	cause give	en in Part I	1.	23e. Did t	obacco us	se contribute t	to the cause of death?
ords	equire sen sig ould b	ted b	- HYPOTHERMLE	_						1 🗆	Yes 2□	]No 3 <b>⊠</b> P	Probably 4 Unknown
of Vital Records,	The la	Comple								24a. Was auto perfo 1 🗆 Yes	psy ormed?	death?	autopsy findings available completion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	er		(Check only			
ō	Phys er this eral di	n: To	1 Yes 2 No  27. Manner of Death	1 ✓ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injun World	4   142		ne 5 ☐ Resi 28d. Describe		Other (Spendary)	ecify)
Division	To the Hospitel or Attending Physicien: within 24 hours elter death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined		Injury ome, farm, st	M reet, facto	10	k? Yes 2□					Rural Route Number,
Ö	tei or / rs efter el Dire ed in b	Cert	4 Homicide	building, etc. (Special	fy)					City or To	wn, State)		ner en en en en en en en en en en en en en
	Mospi 24 hou Funer etely fill	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurre vestigation	ed at the tin	ne, date an pinion, dea	nd place, a ath occurre	and due to the	cause(s) date and	and manner a place, and du	is stated. ie to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier			- 1	9c. Licens						nth, Day, Year)
			1 Kentes			!	KES	- OC		1	MOVEU	BER,	13, 2007
_	10		30. Name and address of person who of SRIRATIA. K	ONERU MI	305	SIL	HIAT +	IOSP	ATI	LOF	BAL	TIMO	RE
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 5 2	32 Registrar's Sign	ature	mil	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10e f per fb 9873 11-20-07 vt State of Waryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** EDRGE 2007 November 13 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Randallstown NorthWEST HOSPITAL Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/15/1917 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1**X** M 2□ F MARYLAND Yrs. **Director** 213-07-8325 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show adleal Examiner must be notified at 1 XYes 2 No Director MD N/A BALTIMORE CITY 10e. Street and Number 1322 10f. Zip Code 10g. Citizen of What Country? 21239 USA Funeral 1332 CEDARCROFT ROAD <del>-21234</del> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced WHITE Completed Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER SHIPBUILDING 8TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic every GEORGE YOUNG ANNA VIRGINIA LADNA ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE W. YOUNG/SON 7908 MARFIELD PL. APT. E NOTTINGHAM, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 Removal from State PARKWOOD CEMETERY 11/19/2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Tue 21286 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Intace tron **Physician** /Medical Due to ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical ed by the attendin detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 The patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November, 13, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Court Road, Randallstown, HD 21133 46d2/12h FISTYOUNI 5401

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:34 P <sup>M</sup> Frank William Zarzecki, Jr. November 11, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year)
Nov. 17,1924 If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1. M 2 ☐ F Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days 217-16-3133 82 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 24 No Maryland Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Clifton Avenue 21012 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1♣1Yes 2☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Butcher Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank William Zarzecki, Sr. Catherine Louise Daily 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn J. Cascio (Sister) 808 Foxwell Road Joppatowne, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Pk. 11/14/07 Glen Burnie, Maryland 21. Signature of Fungral Service Licenses McCully-Polyniak Funeral Home. P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nzumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 26. Place of Death (Check only one)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

<u>Ş</u>

Completed

Be

2

**Funeral** 

Director

show

ortant; if item 27 is marked other than "natural"; or items 23a or 28a-f shov injury or other traumatic event, the Medical Exa<u>miner must be</u> notified at

permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic important: if item 27 is marked other I any injury or other traumatic event, th

72 hours after

Baltimore, Maryland 21215-0036

Examine burial-transit physician Physician/Medical the for

that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

H and ed by the a detached f þ Completed peen page 2 s certificate has Be 2 After this funeral Certification: within 24 hours after death. To the Funeral Director: A filled in by

completely

Hospitai or Attending

State Registrar

Medical

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

29b. Signature and the of certifier

29a. Certifier

(Check only one)

5 ☐ Pending investigation 1. Natural 2 Accident 3 ☐ Suicide 4 ☐ Homicide

6 Could not be determined

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who complet id cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygien 2007

			1 - For State Registrar	State of M	aryland	l / Depa <i>Cer</i>	artmen tificat	t of He	ealth a Death	and M		Reg	en@ () (	7	3662	
	Physici	an	Decedent's Name (First, Middle,								2. Date of Month NOV.		<sup>Day</sup> 2007	Year	3. Time of Di 12:25	
	/Media	cal	Walter E. Ad				4h City	Town or	Location of	of Death	NOV.	0,	4c. County	of Death	12:25	a **
	Examir	ner	70 Park Lane				40. O.ly	East						albot		
Ī	Funeral Director		5. Social Security Number 006-18-9577		e (In yrs. la 85	st birthday) Yrs.	II Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, 05/	1922	9. Birthp Copr Ma1	place (State or F ntry) ne	oreign
	and		Usuel Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City	Limits
	f ehc	to	Maryland Ta	lbot			Fa	ston							1 🗆 Yes 2	No
	deeth with the Maryland ma 23a or 28a-f ehow rmust be notified at	by Funeral Directo	10e. Street and Number	.1.000			10f. Zip					10	g. Citizen of	What Cour	ntry?	
	23a C	aiD	70 Park Lane	2			1	2:	1601				USA	4		
	ems and a	ne	11. Marital Status	12. Was Decedent Armed Forces?		. 13. V	Nas Dece f Yes, spe	dent of His	spanic Ori	gin? (Spe i, Puerto	ecify Yes or Rican, etc.)	No-		ce - Americ ck, White,		
3	rs affe	y Fi	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 XYes 2 If Yes, Give Year or Dates:	<sup>No</sup> 9/13 <b>-</b> /1	6	1 □ Yes	2× No	Specify:				Specif	y: Whi	te	
200-0	within /2 hours affer ene. then "naturel", or ite he Medical Examine		15. Decedent's	Education		16a. Deced	lent's Usu	al Occupa	tion			10	6b. Kind of B			
2	Media	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or !	5+)	(Give life. L	kind of wo	erk done di se retired)	uring mos	t of worki	ng					
N :	ygien ygien t, the	Completed	10			Li	nemar						Elec			
ומוני	od ott	Be	17. Father's Name (First, Middle, L	ast)									aiden Sumai	ne)		
-	d Mer d Mer marke	2	Earl Adams 19a. Informant's Name/Relationsh	n (Type Print)		19h Mailin	a Address	(Street a			VanDu		l City or Town	State Zit	Codel	
	Ithan 27 to rtrau		Bette Adams/Wife				_				1D 216		<i>-</i> , -, -, -, -, -, -, -, -, -, -, -, -, -,			
ב ב	othe		20a. Method of Disposition		20b. Pla	nce of Dispo	sition /Na	ne of			ate	-	0c. Location	- City or To	own, State	
2	Pages nent of ent: If its ury or o		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (Sp		MidS	horeC	remat	ionC	ente	11/	<b>'</b> 08 <b>/</b> 20	007	Cambr	idge,	MD	
Dallillo	permit. Pages 1 and 2 should be filed within 72 hours atter deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are traportent: If them 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at once.		21. Signature of Funeral Service	censee	m 11	20 22	Mame a Mid P. O.	Addres hore Box	s of Facili Crer 1464	matic	on Cer	iter	Rd.	Cambr	idge,MD	) 21(
you, of	Physician Medical Machine prize of second of the prize transit was the prize transit with the prize transit was the prize transit with the prize transit was the prize transit with the prize transit was the prize transit with the prize transit was the prize transit with the prize transit was the prize transi	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	2 © a conseque	once ol):	reti	e uot	Heo	Pi	De	ne	ry D	lseese	Onset and De	Paul 1
	death certific e attending p	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)										ate of deliv	•	ear .
בי'ה ה	requires that the een signed by th hould be detache		Part II. Dther significant condition	s contributing to death b	ut not resul	ting in the ur	nderlying	ause give	n in Part I				acco use con 2 🗆 No		he cause of dea bably 4 ⊟Un	
ָבר בר בר בר  ine la ete has page 2	Completed									a	Vas an utopsy erform es 2		Were autoprior to codeath?	opsy lindings avoinpletion of cau	ailable	
	rnysicien: this certific ral director.	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:		R/Outpatien		Othe			Check or		) nce 6 ⊡Ot	har (C	4.1	
5	ding rnys th. After this funeral dir	n: To	27. Manner of Death	1 ☐ Inpation		28b. Time of		28c. Injury Work	4 🗆 140				v injury occu		ry)	
5	r: Afte	ation	1 Natural 5 Pending 2 Accident investiga		y Year)	Injury	м		:? ∕es 2 🗌	No						
	To the Hospital of Attending Mythin 24 hours after death.  To the Funeral Director: After it completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	and 286. Place of in	jury - At hon c. (Specify)	ne, farm, str	eet, factor	y, office				on (Stre		ber or Rur	al Route Numb	e <i>r</i> ,
	124 hour	edicai (	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner st	of examination	rledge, death on and/or in	occurred vestigation	at the tim	e, date ar pinion, dea	nd place, ath occurr	and due to ed at the ti	the cau	use(s) and m te and place	anner as : , and due t	stated. to the cause(s)	
	vithir To th comp	Me	29b. Signature and title of certifier					c. License					d. Date sign			
			Mohlter	, MD	)			D6	33	59			11/8	107		
	1541		30. Name and address of person v	ho completed cause of a	death (Item	60	Print) 7 [	Lute	2hm	an!	s Li	INE	E, E	ASTO	N, MI 216	)-
	Sta Registi		31. Date filed (Month, Day, Year)	2007 32 Registr	ar's Signate	ile (	este)									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 11:25 A M Jeanne Clopper Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Homewood Health Care Williamsport If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2**X** F Yrs. Director 215-18-2444 14,1922 Maryland 85 July Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified 1 X Yes 2 □ No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 208 East Sunset Avenue 21795 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XNo
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or i 1 ☐ Yes 2 No <u>م</u> Specify 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event. the <u>Administrative Secretary Ai</u>rcraft Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clopper Schley ္ပ George Peter Gearhart Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 East Sunset Ave. Williamsport, MD 21795 <u>Donald L. Anderson-Husb</u>and 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Nov.7,2007 Williamsport, 21. Signature of Funeral Ser 038 by compranded addiffestion Feeting I Home, P.A. 21795 425 S. Conococheague St.Williamsport,MD 23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** an. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 No Day Month Year 4☐Pregnant at time of death ed by the a detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Framiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical (Check only one) 🖏 Iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and life 29d. Date signed (Month, Day, Year)

Registrar

State

MOV 0 6 2007

VH-10

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	,	Cer	tificate of	Death	R	leg. No 20	107	36630
	Physici	an	1. Decedent's Name (First, Middle, La	st)				Date of Dea     Month			
	/Medic		GRACE		BUSSA			11	11	2007	2240 M
	Examin	er	4a. Facility Name (If not institution, given MEMORIAL HOSPITA			4b. City, Town, or CUMBER	r Location of Death			ty of Death EGANY	
-	uneral		5. Social Security Number 6. 9		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9 Rirthn	lace (State or Foreign
	irector			<sup>1□ M 2</sup> ☐F 81	Yrs.	Months Days	Hours Min.	May 6,	, Year) 1926	Coun	WV
Pt.	ų.		Usual Residence of Decedent		h. Town as I as						Od Inside Oibelielle
aryla	show ed at	'n	10a. State 10b. County  MD Allega		ity, Town or Loc Cum	berland				"	0d. Inside City Limits 1√2 Yes 2 No
the M	28a-f lotifie	ectc	10e. Street and Number	ATTY	- Cuiii	10f. Zip Code			10g. Citizen of	What Cour	
with	a or	٥	223 E. Offutt Stre	act		Toi. Zip Gode	21502		_	JSA	.,,
death	ms 2; r mus	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		ace - America	
after	or Ite mine	/ Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	1	Yes 2 No	Specify:	Hican, etc.)	Speci	ack, White,	
UUSO hours af	uraf"; Il Exa	d by	3 Widowed 4 Divorced	Year or Dates:	I dos Daned					WIII	
iaryland < 1 < 1 > 1 > 1 U 30 2 should be filed within 72 hours after death with the Maryland	"nat ledica	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give F	ent's Usual Occup kind of work done O NOT use retired	during most of work d)	ing	16b. Kind of I	Jusiness/inc	lustry
Z with	the N	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	maker			Own H	lome	
	othe vent,	Be C	17. Father's Name (First, Middle, Las.				18. Mother's Nam			ime)	
y and b	arkec atic e	卢	Samuel J. Par					E. (Burch	<u> </u>		
y IVICAT and 2 sh	Department or near an area was in years.  Department or near an area was in the medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship Herman Bussard			g Address (Street E. Offutt	and Number or Rui Street		r, City or Towi berland	ո, State, Zip   Mi	D 21502
Pages 1	t: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Dispos cemetery, crem Tabor Ce	natory or other plac	ce) ¦	Date 11/14/2007	20c. Location	o - City or To	
Dallimor Dermit. Pages	Importan any injur- once.		4 □ Donation 5 □ Other (Special Signature   Furral Service Lice	.57			ss of Facility Ii Funeral Hoi	me, PA	Орин	g oup	1110
U 8.6	5 등 등 의	11 13	1/1/1/1/	1 uu			ginia Avenue:			502	American
		9	23a Parti . Enter the disease, or con shock, or heart failure. List only Imme te Cause (Final	'					rest,		Approximate Interval Between Onset and Death
	sician ledical		disea e or condition resulting in death)	a. MYOCARI		INFAR	CTION	)			1 HOUR
	aminer			b RESPIRA	Washington and Authorities	DIST	RESS				2 Hours
		ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec							-10
certificate be executed	physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. ASPIRAT							2+toves
ficate be ex	cian a burial-		rooming in dealing East	Due to (or as a consec	quence or):						
icate	physi s the l	Medical		_d							
death	been signed by the attending pl should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 🗌	Ectopic pregnanc Other (specify)	у			Date of delive Month	ery Day Year
hat #	d by l	Phy	Part II. Other significant conditions	contributing to death but not re	sulting in the un	derlying cause giv	ren in Part I.	23e. Did to	bacco use co	ntribute to th	ne cause of death?
ecords, P.O.	en signe ould be o	ed by		PIDEMIA	_			1 🗆 Y	′es 2□No	3 ☐ Prob	pably 4 Unknown
· >	ate has be page 2 sh	Completed						24a. Was a autop perfor 1∐ Yes	sy	o. Were auto prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of 2   No
VITAI	ertific actor,	Be	25. Was case referred to medical examiner?	D2-1		Lou	26. Place of Deal				
Phys	this o	P	1 XYes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2	ER/Outpatient		4 Liversing no	ome 5 ☐ Resid			y)
ding	After funer	ion:	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2∐No	zau. Describe n	low injury occi	urrea	
VISION Attending	ector:	fical	3 Suicide 6 Could not b	28e. Place of injury - At h	nome, farm, stre			28f. Location (S	Street and Nun	nber or Rura	al Route Number,
alor S	ai Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ury)			City or Tow	n, State)		
e Hospit	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical (		hysician: To the best of my kn miner: On the basis of examin and manner stated.							
To th	To th	Me	29b. Signature and title of certifier	2. 1		29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
			<b>A</b>	felle Tro.		D00	017505		H {	12/0	+
	6		30. Name and address of person who ANTHONY BOLLING				LAVALE, M	D 21502			
	Sta			32 Registrar's Sign							
	Regist	rar	MONTES	UUI JAN MARIN S	Jan Jan	- Bridge					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar AMEND#19aperi+110/31/07, BWW, Moo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2 y Day Year 1630 M 2007 Anna Aina Beitins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Examiner Mon Glen mills Rockuille 13513 70me66 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Poreign Country) **Funeral** Days Hours 1 □ M 2 F 9 Feb. None Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Ontario Scarborough 1 TX Yes 2 ☐ No Director None 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 51 Lynvalley Cres M1R-2V1 Canada 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give / Year or Dates: 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Commercial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Juris Sermulis ပ္ Marija Grinbergs 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inese Beitins - daughter 13513 Glen Mills Road, Rockville, MD 20850 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 10-31-2007 20c. Location - City or Town, State Department o Important: If any injury or once, Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee en Ann 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Du yo (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of the burial-tran and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) daughter's residence examiner: 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4 Nursing Home 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1—CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Sig ature and title of certifien 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar 31. Date filed (Month, Day, Year) 0CT 3 1 200



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ur mo DME



MO OME

1000428

2101 merical

26

Pork D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OCTOBER 2007 MONTEREY 3Í. 4:15 A M MAE BOWIE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) NOV 10 1919 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2 1 F 212-24-3176 87 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at FREDERICK 1 ZYes 2 No Md. FREDERICK Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HILDERBRAND RD. 5801 704 21 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examine 1 Never Married 2 Mamied 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD SCHOOL FOR Elementary/Secondary (0-12) College (1-4or 5+) DOPT. AUNDRY THE DEAF 12 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BOOTH CHARLES RUTH HILL ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER HALL day 1206 CONAWAGO Dr. FRODORICK MD 21704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Resthauen Mem. Gav. Nov. 5, 2007 Fred, Md 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUN. Itomic 21. Signature of Funeral Service Licensee zury X. 110 WEST SOUTH ST FREDBRIGG MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (a as a consequence f): disease or condition resulting in death) /Medical Examiner angestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): and burial-t P.O. Box 68760, attending physician I for use as the buria certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a detached for a No 9 Unknown signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ ₩ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performe this certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Department 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/200

State

shomas

32. Registra's Signature

MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

Shah

31. Date filed (Month, Day Year) 0 1

D0060417

29d. Date signed (Month, Day, Year)

10

Dr. Frederick

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10-30-2007 2315 Dale Rutledge Bevard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Min. Hours Pennsylvania 218-26-4843 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Frederick 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1599 Carey Place 21701 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Tyyes 2 No If Yes, Give Year or Dates Korean 1 ☐ Yes 2 ☐ No Specify Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 years College (1-4or 5+) Retail Plaza Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Rutledge Bevard Lucille Virginia Ward ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1599 Carey Place Frederick, Md. 21701 Mrs. Faye R. Bevard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5□XOther (Specify)Mausoleum Resthave Mem. Gardens 11/3/07 Frederick, Md. ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Finer J Service 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) adder VRAY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 240 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

The law requires that the death certificate be executed the burial-tran P.O. Box 68760, attending physician for use as the as been signed by the 2 should be detached Division or Vital Records, certificate has been page 2 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director, Certification: To

filled in by

1. Natural

2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

(Check only one)

**Funeral** 

Director

r 28a-f show notified at

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r

Department of Health Important: If item 27 any Injury or other tr once.

**Physician** 

/Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite

3altimore, Maryland 21215-0036

death

140

State Registrar

Medical

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License numbe

Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 □ Yes 2 □ No

29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print) rimary Care. Fred. Md. 21702

5 Pending

investigation

6 Could not be determined

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

			■ Registrar			Ce	lllical	e or i	Deall	ł		Reg. I	No.		
ľ	Physici	an	1. Decedent's Name (First, Middle, L		•						2. Date of I Month	[	Day	Year	3. Time of Death
	/Medio		Mary Lou		rke		4b. City, Town, or Location of Death							2007	11:40A <sup>N</sup>
	Examir	er	4a. Facility Name (If not institution, g 7457 Waters				1			of Death		4c. County of Death			
	*			Sex Sex	7. Age (In yrs	last hirthday	If Under		Airy If Unde	r 24 Hrs.	8. Date of I	Rinth	Ca	rroll	nlace (State or Formin
ì	Funeral Director		577-01-0525	1 □ M 2 🕸 F	102		Months		Hours	Min.	(Month,	Day, Yea	ar)	Cou	place (State or Foreig
1	2		Usual Residence of Decedent		102	•	Oct. 9,					7 g _ 1.	703	wasii	ington D.C
	yland Iow at		10a. State 10b. County		10c. C	ity, Town or Lo	ocation				-				10d. Inside City Limits
	Man I-f sh fied	tor	Maryland Carrol	1	l M	ount A	irv								1 ∐Yes 2 XN
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. (	Citizen o	f What Cou	ntry?
	h witl	al D	7457 Watersv	ille Ro	ad		2	1771				1	U.S.	Α.	
	deat ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Dece	dent of H	lispanic O	rigin? (Sp	ecify Yes or Rican, etc.)	No-		ace - Ameri	
9	after or ite mine	T.	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes If Yes, G	orces? 2 X No		1 ☐ Yes				riidari, etc.)			ack, White, :ifv: Wh:	
<u></u>	ours Iral", Exa	d by	3 X Widowed 4 ☐ Divorced	Year or I	Dates:			20110	Opeany	·-			Spec	my: WII.	rre
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education trade completed		16a. Dece	dent's Usu kind of wo DO NOT u	al Occup ork done	ation during mo	st of work	ing	16b.	Kind of	Business/In	ndustry
2	/ithin ne. han '	ם	Elementary/Secondary (0-12)	College	1-4or 5+)		omema]		1)				0	77	
2	lled v Hygie her t	ပိ	17. Father's Name (First, Middle, La	4		110	Jillellia	Kei	10 Moth	nor'o Name	e (First, Midd	lla Maid		wn Hor	ne
ű	ed fal	Be	,						_					arrie)	
Ĕ	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	မ	Frederick Wil		angerte			/C+ 1		Laura	Ella al Route Nur		rown		0.41
Maryland	d 2 sl th and 7 Is r traur		19a. Informant's Name/Relationship  Stephen F. Burk			I									land 21771
	1 and Health em 27		20a. Method of Disposition	.e - 5011	20b.						Date			- City or T	
Baltimore,	Pages nent of int: If it		1X Burial 2 ☐ Cremation 3		State I	Place of Dispo								•	·
	it. Partitude		4 □ Donation 5 □ Other (Special Signature of Runeral Service Aid		La	ytonsv:	TITE (	Ceme	cery	Nov	. 2, 2	:ψ07	Lay	ytons	ville, Md.
g Ra	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic.		Lovert L.	Will	iams		1eswo 5401	orth Ridg	-Will e Roa	liams ad,	P.A., Damasc	Fur	nera Mary	l Home	20872
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ly one cause on	caused the dea	ath. Do not en	ter the mod	de of dyir	ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Between
	Physician	3 J	Immediate Cause (Final disease or condition	Pne	ımonia									1	Onset and Death  2 Days
	/Medical		resulting in death)	Due to	(or as a conse	quence of):		10							L Dayo
	Examiner		Sequentially list conditions	b											
	po tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	Due to (or as a consequence of):										
	ecute and trans	am	that initiated events resulting in death) Last	c	,										
Š,	oe ex		rooding in dodiny Edot	Due to	(or as a conse	quence or):									
×	ate by sic	dica	•	d											
ox 68/60,	leath certificate be executed attending physician and for use as the burial-transit	Physician/Medical	IF FEMALE:	00- 11											
o n	attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	1□Live	itcome pf pregr	tal death 3[	Ectopic p	regnancy	y					ate of deliv Jonth	'ery Day Year
o.	the a	sic	1 ☐ Yes 2 ☐ Alvo 9 ☐ Unknown	4⊟ Preg 9⊟ Unkr	nant at time of nown	death 51	Other (sp	pecity)				-			,
J.	The law requires that the deal ate has been signed by the att bage 2 should be detached for		Part II. Other significant conditions	contributing to	leath but not re	sulting in the u	nderlying c	ause giv	en in Part	1.	23e. Di	d tobacc	o use co	ntribute to t	the cause of death?
S O	sign d be	d by									1[	Yes	2 ☑ No	3□ Pro	bably 4 ☐Unknow
Ö	w require been sign	Completed													
ě	has has	ld II			181						24a. W	tonsv		prior to co death?	opsy findings available ompletion of cause of
_ 		ပိ		1							1□ Yes	rformed 2	No		2□ No
Vital Records,	Attending Physician: The kindeath.  ector: After this certificate has by the funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or:		h (Check onl				
ō	Physral di	-T	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date		ER/Outpatie		JA	4 L N		ome 5 XRe 28d. Describ				ify)
o	l or Attending Ph after death. Director: After th I in by the funeral	tion	1 Natural 5 Pending 2 Accident investigati	(Moi	nth, Day Year)	Injury	М	28c. Injur Wor 1 □	k? Yes 2[		200. 2000110		ijai y oool		
DIVISION	Atten deat ctor y the	fica	3 Suicide 6 Could not		e of injury - At I	l nome, farm, st	reet, factor			-	28f. Location	(Street	and Nun	nber or Rur	al Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determine	u build	ling, etc. (Spec	ify)						Fòwn, St			
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical C	29a. Certifier (Check only one) Certifying Medical Ex	Physician: To the	e best of my kn basis of examin	owledge, deat nation and/or in	th occurred	at the tir	me, date a	and place, eath occur	and due to t red at the tin	he cause ne, date	e(s) and r and place	manner as s e, and due	stated. to the cause(s)
	o the	Mec	29b. Signatore and title of certifier	V)	- A		290	c. Licens	e number			29d.	Date sign	ned (Month,	Day, Year)
)	⊢ 3 ⊢ ŏ		allen,	Ker	lly	me	0	D54	4749				_		, 2007
	5		30. Name and address of person wh												
			Allen Reilly M	.D. 801	T611 I	House A	venue	, Fr	ceder	ick,	Mary1	and	217	01	

State Registrar

Allen Reilly M.D. 32. Registre's Signature NOV 0 2 2007

Division or Vital Records, P.O. Box 68760.

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00061822 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 Cambridge, MU mil. BRICT, WIOMAICH 32. Registrar's Signature

State Registrar

Medical

31. Date filed (Month, Day, Year)

29a. Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Mor

yn) completed cause of death (Item 23a) (Type, Print)

License number

26.

29d. Date signed (Month, Day, Year)

Cambridge

**Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2, and 1) jury or other traumatic event, the Medical Examinar mone.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

Be

the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

iii	that initiated events resulting in death) Last	C	juence of):			
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 □Ectopio	pregnancy (specify)		23d. Date of delivery Month Day Yo
þ	Part II. Other significant conditions of	oftributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did tobaco	co use contribute to the cause of de
Completed	- HARENTERS	(in)			24a. Was an autopsy performed	
B	25. Was case referred to medical examiner?				eath (Check only one)	
P	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Specify)
	27. Manyler of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred
Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factive)	ory, office	28f. Location (Street City or Town, S.	t and Number or Rural Route Numb tate)
Medical C		ysician: To the best of my kniner: On the basis of examinand manner stated.				e(s) and manner as stated. and place, and due to the cause(s)
Me	29b. Signature and title of certifier	X		29c. License number	29d.	Date signed (Month, Day, Year)

State Registrar

NOV 0

SH-0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 29, 2007 10:05 A M Helen D. Cooper /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Glade Valley Nursing Home Walkersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 30, 1916 5. Social Security Number Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days Hours Months 1 M 2 X F Maryland Director 215-32-8491 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 XYes 2 □ No Maryland Frederick Walkersville Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be 56 W. Frederick Court 21793 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2**X**] No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 9 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important; If them 27 is marked other than any Injury or other transmitted. 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Knoble Estelle Hamilton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17747 Silcott Springs Rd., Purceville, VA 20132 Henry Miller / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cethedral Cem. 11/2/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home art1. Enter the rise set or complications that clus to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. I ist only one cause on e ion line. 1621 Opossumtown Pike, Frederick, MD 21702 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) ARTERY DISEASE CORDMARY YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be HTPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an REMAL FAILURE page 2 autopsy performe Yes 2 certificate 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) r this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director; completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32171 MD 30/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RICHARD L. GOUGH PO BOX 328 WALKERSUILLE MD 1 2007 N 31. Date filed (Month, Da

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c e f per inf e877 3-27-08 wt State of Maryland Pepartment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 October 06:20 AM Dominic Ciuffreda, Jr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis 307 Dellwood Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 5. Sociel Security Number 8. Date of Birth 6. Sex 1 ▲ M 2 ☐ F 7. Age (In vrs. last birthday) Months 06/23/1933 Washington, D.C. 579-42-4725 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Florida Haryland Monroe Anne Arundel Duck Key 1 ☐ Yes 2 XNo Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 156 Indies Drive (North) 33050 307 Dellwood Court 21401 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 █ No White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beer Wholesaler Beverage Distribution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dominic Ciuffreda, Sr. Marguerite B. Wells 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Dale Ciuffreda/Wife 307 Dellwood Court, Annapolis, Maryland 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 10/28/2007 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland Figure 1 Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Prostate Cancer 12 years disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Department of H Important: If Ite any Injury or ot

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

Examiner

Completed by Physician/Medical

Be ၉

Certification:

Medical

State

Registrar

29b. Signature and title of certifier

Harvey Steinfeld.

OCT 3 0 2007

31. Date filed (Month, Day, Year)

30. Name and address of post in who completed cruse of death (Item 23a) (Type, Print)

3 Registrar's Signature

M.D

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

certificate be executed signed by the attending physician and be detached for use as the burial-tran

within 24 hours after death To the Funeral Director: , completely filled in by the f

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	23d. Date of delivery Month Day Year			
_	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?			
Coronary Artery Disease					
		24a. Was an autopsy performed?  1 Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No			
25. Was case referred to medical examiner?	26. Place of Death (Check only one)				
1 Yes 2 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Ho	lame 5 Residence 6 □Other (Specify)			
27. Manner of Death  Natural 5 ☐ Pending 2 ☐ Accident investigati	n (Month, Day Year) Injury Work?  M 1 Yes 2 No	28d. Describe how injury occurred			
3 Suicide 6 Could not 4 Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier Check only const	hysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurred and the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)			

29c. License number

D05158

6131 Shady Side Road, Shady Side, Maryland 20764

29d. Date signed (Month. Dav. Year)

10/27/2007

DHMH 17 Rev 1/2001

To the Hospital

**Physician** /Medical Examiner requires that the death certificate be executed burial-tra Division or Vital Records, P.O. Box 68760, the attending pl ed by the a signed by

page 2 should certificate has funeral director, this After t 124 hours after death.

The Funeral Director: A pletely filled in by the fi completely

Part II. Other significant conditions of	entributing to death but not res	sulting in the underlying	cause given in Part I.		se contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☑ Unknown
- Seune	decono	htronia	R	24a. Was an autopsy performed? 1  Yes 2 ► No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (Check only one)    Other: 4   Nursing Home 5   Residence 6   Other (Specify)				
27. Manner of Death 1 Manual 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	ysician: To the best of my known in the basis of examinand manner stated.				and manner as stated. place, and due to the cause(s)

29c. License number

00 60

29d. Date signed (Month, Day, Year)

21701

0

or Attending Physician:

Hospital

within 24

State Registrar

Medical

31. Date filed (Month 17, 3 and 2007

29b. Signature and title of

Ghulum Abbas 400 W. Seventh St., Frederick, MD Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	· ·	artment of Health and Matificate of Death	ental Hygier	2007 30041
	Physician /Medical Examiner	an	1. Decedent's Name (First, Middle, Last)  MARY  EH	hel Cust	ìs	2. Date of Death Month	Day Year 5:27 A.M
		er	4a. Facility Name (If not institution, give street  3833 Holland Cross)  5. Social Security Number  6. Sex		4b. City, Town, or Location of Death  AR  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	4c. County of Death  On ERSET  9. Birthplace (State or Foreign
	Funeral Director		2 B - 24 - 0 € 14 1 M 2 Usual Residence of Decedent		Months Days Hours Min.	(Month, Day, Yes	ar) Country)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23s or 28e-f show any injury or other treumatic event, the Modeal Examinational Examination and once.  To Re Completed by Funeral Director	ctor	10a. State 10b. County  Om ERS	10c. City, Town or Low  Mario			10d. Inside City Limits 1 ☐ Yes 2 💆 No
		al Dire	10e. Street and Number 28 233 Holland Cross:	ng RD	10f. Zip Code 21838	10g. (	Citizen of What Country? U.S.A
920		<u>주</u>	1 Never Married 2 Married 1 (	TYes 29⊄No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto Yes 2 KNo Specify:	ocify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036		mpleted	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted) /Give	lent's Usual Occupation kind of work done during most of worki O NOT use retired)  AKER	ng	Kind of Business/Industry  Williams Co.
Maryland 2		0	17. Father's Name (First, Middle, Last)  Ray mond Miles		18. Mother's Name	(First, Middle, Maid	len Surname)
			19a. Informant's Name/Relationship (Type, Pr	Daughtee 5285	g Address (Street and Number or Rura Bivens PD Ma	Cion, UD	21838
Baltimore,			20a. Method of Disposition  1 ☆ Burial 2 □ Cremation 3 □ Remov  1 4 □ Donation 5 □ Other (Specify)	al from State	natory or other place)	20c.	Location - City or Town, State  A Rian, MD
Balt			21. Signature of Funeral Service Licensee	. 121	Name and Address of Facility And Ne 39 Hampdon Ave	thony E. W. Princess	
E	law requires that the death certificate be executed  as been signed by the attending physician and  as should be detached for use as the burial-transit  and	dical Examiner	Sequentially list conditions, b	Due to (or as a consequence of):	Non Small CH	1	Inferval Batween Onset and Death
P.O. Box 6	at the death certificaby the attending place tached for use as the tached for use as the tached for use as the same of the sam	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	quires that I n signed by uld be deta	his certificate had director, page	Part II. Other significant conditions contribut	ing to death but not resulting in the ur	nderlying cause given in Part I.		o use contribute to the cause of death?  2 📉 No 3 🗆 Probably 4 🗀 Unknown
al Reco	The ate h page					24a. Was an autopsy performed 1 ☐ Yes 2 🔀	
	ling Phys h. After this funeral di		25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No ☐ Hospits  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	al: 1 ☐ Inpatient 2 ☐ ER/Outpatien a. Date of Injury (Month, Day Year)  28b. Time of Injury	t 3 DOA Other: 4 Nursing Ho	n (Check anly one) me 5 Kesidence 28d. Describe how in	6 □Other (Specify) njury occurred
Divis	in Little	Certification;	3 Suicide 6 Could not be determined 280	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	the Hospitel hin 24 hours a the Funerel I npletely filled	Funer Funer tely fill	(Check only 2 Medical Examiner: C	To the best of my knowledge, death In the basis of examination and/or inv Ind manner stated.	occurred at the time, date and place, restigation, in my opinion, death occurr	and due to the cause ed at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	withii To th	Σ	29b. Signature and 11/1 of certifier		29c. License number $D  20507$	29d. I	Date signed (Month, Day, Year)
8	EB		30. Name and address of person who completed a SCPH Grasso	ed cause of death (Item 23a) (Type, I 145 E. Carrol S		lisbury,	MD 21801
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 2 200	32. Regetrar's Signature	don't		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** masor NOVEMBER 2, 200 /Medical 4a. Facility Name (If got institution, give street and number 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 27, Birthplace (State or Foreign Country) **Funeral** Months Hours 1XM 2□F <sup>Year)</sup> 2007 Director MD Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show at 'natural", or Items 23a or 28a-f sh dical Examiner must be notified 1 XYes 2 □ No Director PA Franklin Waynesboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 221 North Broad Street 17268 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on nent of Health and Mental Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Never worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental Tyler W. Ditch Sabrina L. Atherton 2 or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 ls Sabrina L. Ditch 221 N. Broad St., Waynesboro, mother PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 X Removal from State Burns Hill Cemetery Nov 7, 2007 Waynesboro, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 S. Broad St., Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed burial-tran Due to (or as a consequence of) P.O. Box 68760, physician s the buria Physician/Medical attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Nnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ٩ After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State Registrar 31. Date filed (Month, Day, Year) NOV 1 5 2007

ITM

29b. Signature and title of certifier

30. Name and address of person wh

2. Registrar's Signature

MUSINGS BALTIMON MA

29d. Date signed (Month, Day, Year)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00061011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death oct. 1, 2007 **Physician** 0942 Dashen Marv Margaret M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 270771941 1 □ M 2 🗗 F Months Days 66 Flint, MI. Director 382-40-7304 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show ns 23a or 28a-f show must be notified at CA. San Diego La Jolla 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 92037 USA 9808 Claiborne Square Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
In: If item 27 is marked other than "natural", or Iter
Iny or other traumatic event, the Men Cal Examiner.
Iny or other traumatic event, the Men Cal Examiner. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify. þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
School Teacher Elementary/Secondary (0-12) College (1-4or 5+) Elementary School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Kelleghan Carmelita McRae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4507 Cheltenham Dr. Bethesda, Maryland 20814 Monica Lee Dashen/Daughter 20b. Place of Disposition (Name of cometery, crematory or other place)

El Camino Mem.Pk. 10/12/2007 San Diego, California 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 ☐ Cremation 3 X Removal from State 5 Other (Specify) 4 ☐ Donation/ Funeral Service License e 21. Signatu e PHILIPADS RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrythmia /Medical Due to (or as a consequence of) Examiner Cardiac Valve Disease Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpatient 70 2 KER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fred Thaler MD 8600 Old Georgetown Rd.Bethesda, Md 20814

31. Date filed (Month, Day, Year)

OCT 3 1 2007

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 12:01 PM November 4,2007 Shirley Marie Davis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🛛 F Hours 14, 1935 Maryland Director June 217-30-5646 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Directo Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 18205 Manor Church Road 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 No Specify: 2 Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy C. Barnhart Jr. Dorothy E. Moats 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18211 Manor Church Road Boonsboro, Maryland 21713 Ann M. Churchey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Manor Cemetery Nov. 7, 2007 Boonsboro, Maryland 4 Donation 5 Other (Specify) Usborne Funeral Home P.A. 425 S. Conococheague St 21. Signature of Funeral Service Licensee Williamsport, Maryland 21795 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PANCREATIC CANBER Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2L No 1 ☐ Yes 2 ☐ No 25. Was case referre examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident

Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transi and P.O. Box 68760, signed by the a Division or Vital Records, or Attending Physician: nours after death.

neral Director: After this
filled in by the funeral d within 24 hours a

To the Funeral I To the Hospital

"natural", or Items 23a or 28a-f show edical Examiner must be notified at

Medical

other traumatic event, the

al Hygiene.

Mental is marked

of Health Item 27 I

Pages 1 and 2 should

filed within 72 hours after death

altimore, Maryland 21215-0036

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

2H-40

State Registrar

31. Date filed (Month, Day,

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

29c. License number

Walli county Hanta

pleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

			For State AMEND#100 month	State of	_			nt of H		and Me	-		0007	20015
	100		Teglstra MFID#19a, perFF  1. Decedent's Name (First, Middle, Last		HW,MCC	0 061	unca	ie oi i	Jeain		2. Date of De	Reg. Ne	2001	3. Time of Death
į.	Physici		Leticia G. Escol								Month Octobe	or 1	3, 2007	4:15 P <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give		per)		4b. City	, Town, or	Location of		OCCODE		c. County of Death	4.13 1
			2709 Plyers Mil	1 Road			Sil	ver S	pring	Ţ		Mo	ontgomery	
e.,	Funeral		5. Social Security Number 6. Se	x 7	Age (In yrs.			r 1 Year	If Under Hours	2	B. Date of Bir (Month, Da	rth	9. Birthr	place (State or Foreign
ь	Director		430-02-0133	M 2 <b>∏</b> F	54	Yrs.					1ay 12	-		
	and w	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location									1	0d. Inside City Limits		
	Maryl f sho	ō	M1 . 1 M											1 □Yes 2 □No
	r 28a	Director	Maryland Montgomer 10e. Street and Number	у	S1.	lver S	pring 10f. Zi	p Code				10g. C	itizen of What Cour	ntry?
	h with	a D	2709 Plyers Mill R	oad					20902	•		Uni	ted State	25
	ems ems	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Dece				ify Yes or No ican, etc.)	D-	14. Race - Americ Black, White,	an Indian,
36	after or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	₹No					Mexi				her
ğ	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Date	es:	160 Doco	dont's He	ual Occurs	ation			16h	Kind of Business/In	als reduces
5	in 72 i "na" ledici	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		16a. Dece (Give	kind of w	ork done d use retired	during mos ()	t of working	9	1	ernation	
212	with iene. thar the M	mo	Elementary/Secondary (0-12)	College (1-4	for 5+)	Soci			,			Dev	elopment	
ğ	il Hyg other	Be C	17. Father's Name (First, Middle, Last)			1			18. Mothe	er's Name (	First, Middle	, Maide	n Surname)	
<u>la</u>	should be and Mental marked o	To B	Ildefonso Garcia						Carm	en Or	rona			
Baitimore, Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7)	pe. Print) - spou	80		_					-	or Town, State, Zip	,
2	and ealth m 27		Luis H. Escobar Luis Garcia spous	<u>- Spou</u>					-				ring, MD	
0	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from St	ate	Place of Dispo cemetery, crea			1	0-23-	-2007		entwood, N	
	permit. Pag Department Important: any injury conce.		4 □ Donation 5 □ Other (Specify,		For	rt Line								עני 
g	permit. Pag Department Important: I any injury o		21. Signature of Furreral Service Licens	ee	5				ss of Facilit		ple T		ite .e, MD 208	252
۰			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cau	used the death								.e, MD 200	Approximate
	Physician		Immediate Cause (Final	ne cause on ead	ch line.	100	1000		and A	C. 44	1004	_		Interval Between Onset and Death
)	/Medical		disease or condition resulting in death)	Due to (or	r as a consequ	uence of:	0	rwru	7	000	الانعا			
	Examiner		Sequentially list conditions	, C	envi	ical	0	an	ćer	2				
	De tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):								
	ecute and trans	хаш	that initiated events resulting in death) Last	c	r as a consequ	nesse off:								
8/60,	death certificate be executed e attending physician and d for use as the burial-transit			Due 10 (0)	as a consequ	deride oi).								
280	ficate phys s the	edical		d										
X Q Q	eath certific attending p for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									23d. Date of delive	ery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregna	th 2□Feta nt at time of d		JEctopic   Other (s	pregnancy pecify)					Month	Day Year
J.	at the by th tache	hys	9 Unknown	9□ Unknov	vn									
	requires that the de een signed by the a nould be detached	by F	Part II. Other significant conditions co	ntributing to dea	th but not resi	ulting in the u	nderlying	cause give	en in Part I				use contribute to t	
Vital Records,	w require been si should b	ted									1 🗆	Yes :	2LXINo 3∐ Prob	oably 4 Unknown
ခ်	- Q 70	Completed									24a. Was	psy	prior to co	ppsy findings available mpletion of cause of
<u></u>	62 0										1□ Yes	ormed?	death? lo 1 ☐ Yes	2 □ No
	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		55/0		OA Othe	or.		(Check only			
ō	Physic ruthis eral di	: To	1 ☐ Yes 2XXNo  27. Manner of Death	28a. Date of		28b. Time o		28c. Injun	4 LI NU		e 5 LXRes 3d. Describe	_	6 □Other (Specification occurred)	(y)
0	Attending Physician: r death. ector: After this certific by the funeral director,	ıtlor	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	Day Year)	Injury	М		k? Yes 2∐l					
DIVISION	after death Director: /	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o	f injury - At ho g, etc. <i>(Specif</i>	ome, farm, str	eet, facto	ry, office		28	Bf. Location (		and Number or Rura	al Route Number,
5	tal or rs afte	Certification:		541101115	, o.c. (opeon							Old		
	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun		29a. Certifier 1 CertifyIng Phy (Check only 2 Medical Exam	Iner: On the bas	sis of examina	wledge, deat ation and/or in	h occurre vestigatio	d at the tin n, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time	e cause( , date a	s) and manner as s nd place, and due t	stated. o the cause(s)
	o the Hos vithin 24 hr o the Fur ompletely	Medical	one)  29b. Signature and title of pertifier	and manne	er stated.		20	c. License	number			204 D	ate signed (Month,	Day Year)
			200. Orginatura arra or certific					D476						
,	9 (10)		30. Name and address of person who c	omnleted cause	of death (Item	n 23a) (Type	Print)	טיוים	12			- 00	ctober 16	, 2007
			Paul Mackoul, MD 8					ıi to	/, Q /.	Do+L	o a d =	MD '	2001/	
	Sta	ite	<ol> <li>Date filed (Month, Day, Year)</li> </ol>	327 Re	gistrar's Signa	ature	. 45 -		<del>→74,</del>	DECIN	<del>-sua,</del>	1,117 °	<del>44014</del>	
	Registr	ar	OCT 3 1 200	1 19.00	118 1	in China								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 36646 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Mykola Francuzenko October 0 28 2007 1351 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ F Hours 83 Director 087-36-0598 November 25,1923 Ukraine Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16524 Jilrick Street 20853 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Writer Journalism 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Alexander Francuzenko Sophia Tereshchenko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaroslawa Francuzenko - Wife 16524 Jilrick Street, Rockville, Maryland 20853 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Andrew Ukrainian Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/3/2007 South Boundbrook, NJ 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Clark Domel 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UL mon HOUR /Medical Dux to (or as a consequence of) Examiner Sequentially list conditions, many, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Display to for as a consequence off physician and the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical for use as cate has been signed by the attending , page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 2 No director, 25. Was case referred to medical Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 27. Manne of Death 28a. Date of Injury (Month, Day To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Year! 1 Natural Iniun 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 035965 OCTOBER 29, 2007 30. Name and address of person who completed cause of death-(Item 23a) (Type, Print), DAVID B. HARDING, M.D. 18111 CRINCE OHILIPDR. #300 OCNEY, MD. 2083) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 31 Registrar

State of Maryland / Department of Health and Mental Hygiene 36647 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carrie Irene Fawcett 2007 October 26 8:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6535 Rimrock Road New Market Frederick 8. Date of Birth (Month, Day, You Oct. 10, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Months Days Hours Min 186-16-1847 1 M 2000 85 1922 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Anne Arundel Riva 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 3073 Tudor Hall Road 21140 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXIIo Specify. White 2 Specify: 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Clegg Anna Marie Hubble 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Byrd/daughter 6535 Rimrock Road New Market, Maryland 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland MD Veterans Cemetery 10/31/2007 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small cell lung carcinoma resulting in death) /Medical Due to (or as a consequence of) Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of)

**Physician** Examiner

signed by the a

page 2 should

director

this funeral

hours after death

filled in I 24 hours a Funeral I

Physician/Medical

ģ

Completed

Be

2

Certification:

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

9 Unknown

25. Was case referred to medical examiner?

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 XNatural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 mon 1 Yes 22 No

5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

3 □ Ectopic pregnancy

23d. Date of delivery Month Day

1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Рм

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hospital:

1 Inpatient

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed? 2**/2)(**\0

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Daughter's house Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 🔀 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 DOA

29b. Signature and title of perting

29c. License number D65635

29d. Date signed (Month, Day, Year) 10/29/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Holly Dushkin, MD 900 Bestgate Road, Suite 300, Annapolis, Maryland Holly Dushkin, MD

State Registrar

OCT 3 0 2007

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiana / De	epartment of F Certificate of A	ieaith and i Death	nentai Hyg R	leg. No. $20$	7	36648		
	Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month		ear	3. Time of Death		
	/Medic		Marchand M. Frie			T., 61. 7			26, 200		2:45 P M		
	Examin	er	4a. Facility Name (If not institution, give Shady Grove Adver		ital	Ab. City, Town, o	Location of Death		4c. County of Montg		rv		
200	Funeral		5. Social Security Number 6. S		(In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			-		
	Director		370-30-7071	□M 2 <del>Q</del> F	70 Yrs	Months Days	Hours Min.	Month, Day Feb. 15	, 1937 1	Year) 1937 9. Birthplace (State or Foreign Country) Maryland			
and	AC I		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside City Limits		
Mary	-f sho	tor	Maryland   Montgome:	ry	Germant	own		1 ∐Yes					
h the	or 28a a.noti	irec	10e. Street and Number		-	10f. Zip Code	10f. Zip Code 10g.				try?		
ath wi	23a c ust b	ral	19141 St. Johnsbu	ry Lane		20876			United S				
d 21215-0036 filed within 72 hours after death with the Maryland	ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔼 N If Yes, Give		<ol> <li>Was Decedent of H If Yes, specify Cub:</li> <li>1 ☐ Yes 2 No</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		White,	etc.		
Maryland 21215-0036 d 2 should be filed within 72 hours af	tural" al Ex	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	16a D	ecedent's Usual Occup	ation		Specify: 1				
-15- in 72	n "na Medic	Completed	(Specify only highest gra	de completed)		Give kind of work done fe. DO NOT use retired	during most of work	king	TOD. KING OF BUSIN	1633/111	dustry		
Z12	giene er tha th.	No.	Elementary/Secondary (0-12)	College (1-4or 5	Hor	memaker			Own Hom	.e			
	nd Mental Hygie marked other i umatic event, tb	Be	17. Father's Name (First, Middle, Last)					, ,	Maiden Surname)				
aryla	Men narke	우	Rudolph Waldo McDu				Ruth He						
Mar d2sh	rai		19a. Informant's Name/Relationship (Carl Joseph Fries	<i>lype. Print)</i> (Husba:	1	lailing Address <i>(Street</i> 141 St. Joh					*		
ත <u>ි</u> දූ	of Health Item 27 rother tr		20a. Method of Disposition		20b. Place of D	isposition (Name of	1	Date	20c. Location - Ci				
Baltimore, permit. Pages 1 ar	Department of Important: If It any Injury or once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )			crematory or other place. Souls etery	Nove	mber 1,	Carmanto	T.773	Maryland		
Balti permit.	partm portal y Inju		21. Signature of Funeral Service Liver		, den	22. Name and Addre			ral Home	wir,	Maryrand		
n a	을 표 등 당	(3)	Mful	Ita	1	N E. Deer	Park Dr	ive, Gai	thersbur		MD 20877		
			23a. Pa 1. E 'er he d'ea e, or com slock, o'heart fallure. List only	rest,		Approximate Interval Between Onset and Death							
	ysician Medical		Immed ate Cause (Fin I disease republion resulting in de Th)		ial Infa								
	caminer			Due to (or as a	a consequence of)					1			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	υ.	a consequence of)	:				-			
cuted (	nd ransit	Examiner	that initiated events	C									
68760, ificate be executed	physician and s the burial-transit		resulting in death) Last	Due to (or as a	a consequence of)								
<b>58760,</b> ficate be ex	physics the t	edical		d				<del></del>					
Box (	attending for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 □ Fetal death	3 □Ectopic pregnance			23d. Date	of delive	ery		
. 0	he atte	hysician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregnant at 9□Unknown		5 ☐ Other (specify) _			Month	1	Day Year		
hat the	d by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions of	ontributing to death bu	it not resulting in th	ne underlying cause giv	en in Part I.	23e. Did to	hacco use contrib	ute to ti	ne cause of death?		
VITAL RECORDS, sician: The law requires t	signed I	d by	Tarkii. Galor olgililloani oonaliiono	onthibuting to document	it not recounting in a	ic underlying dadoc giv	on in varia				ably 4 🛣 Unknown		
CO N red	should t	Completed						24a. Was a	n 24b. We	re auto	psy findings available		
The law	has Je 2	duic						autops perfor	sy prie med? dea	or to co ath?	mpletion of cause of		
Ita an:	certificate rector, pag	Φ	25. Was case referred to medical				26. Place of Dea	1 → Yes th (Check only or		]Yes	2 <del>∏</del> No		
r V	.≌ <del>≅</del>	To B	examiner? 1 ☐ Yes 2🌠 No	Hospital: 1 X Inpatie	nt 2 ☐ ER/Outpa	atient 3 DOA Oth	er: 4 ☐ Nursing He	ome 5 ☐ Resid	ence 6 ☐Other	(Specit	y)		
DIVISION OF I or Attending Phy	h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		iry Wor		28d. Describe h	ow injury occurred				
ISIO ttend	tor: the	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		ry . At home farm	M 1 □	Yes 2 □ No	29f Location (S	troot and Number	or Pur	J Pouto Number		
Ior A	after death Director: I in by the	Certification:	4 ☐ Homicide determined	building, etc	. (Specify)	, street, factory, office		City or Tow	treet and Number n, State)	or mura	ir rioute Number,		
DIVISION OF VITA To the Hospital or Attending Physician:	e Funeral Directer of Funeral Directer of Ferein Filled in by		29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowledge, o	leath occurred at the ti	me, date and place	, and due to the o	cause(s) and manr	er as s	tated.		
the H	in 24 the Fu	edical	one)	and manner sta		or investigation, in my o							
Tot	within 2  To the comple	Σ	29b. Signature and title of certifier			29c. Licens D605			29d. Date signed (		**		
3	O	1.1	> 2/6 de				40		October	49,	2007		
			30. Name and address of person who Thomas J. Odar, $M$	·			Rockwill.	o Marul	and 2005	Ω			
y.	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	ır's Signature		LOCKVIII	c, maryr	.4114 2003				
	Registr	ar	OCT 3 1 20	31 Blesse	1. K. K.	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36649 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year CARL /Medical HOTT 11 2007 0816 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director Dec 11, 220-34-1974 1934 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at WV Hampshire Romney Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. HC 63 Box 3400 26757 USA by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) College (1-4or 5+) **Bus Driver** D.C. Transit Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Walker Hott Anna Laura Wilson Hott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) wife HC 63 Box 3400 WV 26757 Beverly Hott Romney Important: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Injury or Rocky Gap Veterans Cemetery 11/14/2007 Flintstone MD 4 Donation 5 Dother (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a First. Early the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a lock or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immedi Cause (Final disease or condition resulting in death) **Physician** Samuel OYOPAM SUVI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to import the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3

☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 22 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ۹ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hour the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 29b. Signature and title of çertifi 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Gupta

NOV 1 5 2007

31. Date filed (Month, Day, Year)

D0033280

625 Kent Avenue, Cumberland, MD 21502

Nov 12, 200,

				epartment of Health and Certificate of Death		ene g. No. 2007	36650				
	Physici		Decedent's Name (First, Middle, Last)  MARCELINE HOOD		2. Date of Death Month OCTOBER	Day 2007	3. Time of Death 7:23 P M				
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death					
	A COLUMN TO THE		FREDERICK MEMORIAL HOSPITAL	FREDERICK		FREDERIC					
I A	Funeral Director		5. Social Security Number  157 - 18 - 341/k  G. Sex  1 M 2 F Reg (In yrs. last birth  82 Y1  Usual Residence of Decedent		9. Birthplace (State or Foreign Country) MA.						
	/land low		10a. State 10b. County 10c. City, Town				10d. Inside City Limits				
	e Mar 3a-f st	ctor	MD, FREDERICK FRED	ERICK			1 Yes 2 No				
	th with th 23a or 24 ast be no	Funeral Director	10e. Street and Number 5670 WADE COURT UNIT	10f. Zip Code 21703	10	g. Citizen of What Co	untry?				
0030	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  I □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> <li>1 ☐ Yes 2 ☐ No Specify:</li> </ol>	pecify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: BL	e, etc.				
5	72 hou natura icai E	ted	15 Decedent's Education 16a, D	ecedent's Usuai Occupation	rking 1	6b. Kind of Business/					
7	within 7 ene. than "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of wo. life. DO NOT use retired)	Kirig	Home					
ם ע	be filed ttal Hygi d other event, til	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, M						
ylai	2 should be and Mental is marked o	<b>To E</b>	John Brown	<b>I</b> da	Sher.						
Z N	and 2 sh ealth and n 27 Is n er traun			Mailing Address (Street and Number or Ri 570 WADE COURT							
ore,	0 0		1 Runal 2 Cremation 3 Demoval from State Cemetery,	Disposition (Name of crematory or other place)	1	Oc. Location - City or					
	permit. Pages Department of I Important: If ite any injury or or once.		4 □ Donation 5 □ Other (Specify) FAIRV	itu cem. Oct.	30,2007	FREDER	ICIE, MD.				
Ö	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee Rollin	22. Name and Address of Facility & IIO WEST SOURT	ST FRO	EDERICK	MO 21701				
	100		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arre		Approximate				
I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   Gartric 04	tlet obstructi	00		Onset and Death				
	Examiner		Due to (or as a consequence of	tlet obstruction			HOULS.				
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:							
ŕ	ificate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last C Due to (or as a consequence of	:							
00/00	ate be hysicia the bur	edical	d								
	- D =		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of del	iverv				
5	The law requires that the death certil ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 menths?  1  Yes 2 No 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year				
colds, r	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?				
5	law req	Completed		-	24a. Was an		stopsy findings available				
ב ה	sician: The law s certificate has b irector, page 2 si	Com			autopsy perform 1∐ Yes 2	ed death?	completion of cause of				
<u> </u>	sician s certifi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo  Hospital: 1 ☐ Inpatient 2 ☐ €R/Outp	Other	ath (Check only one		-16.1				
5	ng Phy ter this neral d	-	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Inj	ne of 28c. Injury at	28d. Describe ho	nce 6 Other (Spec w injury occurred	ciry)				
200	ttendil leath. tor: A the fu	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	Opt Leasting (Ot-	ant and the same and the					
2	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate in completely filled in by the funeral director, page	27. Mannet at Death   27. Mannet at Death   28d. Describe how injury occurred   28d. Describe how inju									
	Hosp 24 hou Fune etely fil	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, (Check only one) 2 ☐ Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as ate and piace, and due	s stated. e to the cause(s)				
	To the within To the comple			29c. License number	29	d. Date signed (Mont	h, Day, Year)				
				00062223		10/23/07					
F			30. Name and addressjof person who completed cause of death (Item 23a) (T. PAYEEN BULARUM MD 1967	JORIVE, FRIDER	CE MP	- 21782	,				
Ī	Sta Registr	ite	30. Name and address of person who completed cause of death (Item 23a) (The Ayern Bolanum MD 196 7) 31. Date filed (Month, Day, Year)  32. Registrat's Signature	x Sporte	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08386 State of Maryland / Department of Health and Mental Hygiene Pamela L. Hahn 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 28, 2007 Year 0138 hrs Medical Examiner Pamela Lynn Hahn 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Woodshoro 4 Wood Street Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min Country) Maryland Director M 2 X F 45 Yrs 08/10/1962 215-84-1561 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. anti- If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Frederick Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe 13426 Penn Shop Road 21771 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 X Married 2 X No Yes Yes 2 X No specify: White If Yes, Give Year Divorced ⋧ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Auditor United Health Care 18.Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ella Mae Earp Be William Orlando Shirk (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) ٩ 21771 Maryland Melissa Long/ Daughter 13426 Penn Shop Road. Mt. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State mportant: 11/2/2007 Mt. Airy, Maryland Pine Grove Cemetery Donation 5 Other Specify. 22. Name and Address of Facility
Stauffer Funeral Home P. A. 21. Sign of Funeral Service Licensee Frederick. 1621 Opossumtown Pike. Maryland21702 Approximate Interva art I. Enter the disease, or complication, y at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed cal **AMENDED** UNPENDED by the attending physician sched for use as the burial -Physician/Medi 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 ✓ No 3 Probably 4 Unknown ò Completed Records. has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 No ✔ Yes 2 certificate h 1 🗸 Yes 26.Place of Death (Check only one) director, 25. Was case referred to medical of Vital Be Hospital: Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 1 ✓ Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject shot Certification FOUND: Division Yes 2 V No Natural Pending 0119 hrs Oct 28, 2007 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State)
4 wood stree, woodsboro, MD Suicide determined (Specify) Single Family 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 29, 2007 O.C.M.E.

10

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

1ach

Zabiullah Ali, M.D.

31. Date filed (MOCTO)

ull

30. Name and address of person who completed cause 1 death (Item 23a)

2007

Assistant Medical Examiner

Registrar's Signature

111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 2007 **Physician** Month 11:35P M Frances Hester October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3335 Arundel on the Bay Rd. Annapolis
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Anne Arundel 8. Date of Birth (Month, Day, Dec 22 9. Birthplace (State or Foreign Country) Virginia Age (In yrs. last birthday) **Funeral** Days <sup>Year)</sup> 1926 1 □ M 2√2 F 80 Yrs 231-26-8993 Director Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at ty⊡Yes 2□No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3335 Arundel on the Bay Rd. 21403 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 2 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aaron Boone ပ Julia Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 4 0 3 Clyde Copeland(Son) 3335 Arundel on the Bay Rd. Annapolis, Md. Pages 1 a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 10-30-07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licenses Winname Reductions of &acilions Mortuary, P.A. 821 West St. Annapolis, Md. 21401 se MO0483 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final meta **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cel Ten Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed and physician an s the burial-ti Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as t signed by the attending a IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months. Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation within 24 hours arter occ...

To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 0 5 3 3 0 6 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State OCT 3 0 2007 Registrar

900

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m)

DHMH 17 Rev 1/2001

Rd ste 300 Annapolis MD 21401

		-	For State Registrar		State of Ma	aryland	Cei	artme <i>rtifica</i>	nt of H te of L	Death	Mentai Hy	rgiene Reg. No		36653	
i	Physicia /Medic		Decedent's Name (Fire V)	st, Middle, Las irginia		JONES					2. Date of Do Month Novem	Da	y Year 4, 2007	3. Time of Death	
	Examin		4a. Fecility Name (If not					4b. City	, Town, or	Location of Deat		4c. County of Death			
			17809-A Bro						gerst		Mashington				
	Funeral Director		5. Social Security Number 219-66-0220	) 1[	7. Ag ☐ M 2 12 F		52 Yrs.	Months	Days	If Under 24 Hrs Hours Min.		av. Year	9. Births Cour 954 Mary	place (State or Foreign htry) Land	
	and w	-	Usual Residence of Dec 10a. State 10b	edent . County		10c. City	, Town or Lo	cation						Od. Inside City Limits	
	Many -1 ehc	ğ	Maryland Wa	shingt	on	На	gersto	wn						1 ☐ Yes 2X No	
	r 28e	Irec	10e. Street and Number					10f. Z	ip Code			10g. Ci	tizen of What Cour	ntry?	
	23a o	alD	17809-A Bro	oadford	ing Road			21740				τ	J.S.A.		
0000	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Depertment of Heath and Mental Hygiene. Important: If them 27 is marked other then "netures", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married  3 □ Widowed 4 🔀	7.0	1 ☐ Yes 2 ☑ No			Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☒ No Specify:					No- 14. Race - American Indian, Black, White, etc.  Specify: white		
0-017	thin 72 ho e. en "netur Medicel	Completed	15. (Specify or Elementary/Secondary	Decedent's Ed	ucation de completed) College (1-4or 5	5+)		kind of w DO NOT	rork done d use retired	ation during most of wo	orking	16b. Kind of Business		dustry	
7	or the	Con	10		0		ho		aker				ner own h	ome	
a a a	be fit d oth	Be	17. Father's Name (First,							18. Mother's Na	me (First, Middle				
2	narke	၉	Marvin Watson Janis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City										Vilburn	0.41	
Z Z	d 2 sl th end 7 ie r		Marvin Jone					-							
ย์	Heal Heal tem 2		20a. Method of Dispositi		-	20b. Pf	ace of Dispo	sition (N	ame of	ording i	Date Ha	20c. L	coation - City or To	own, State	
Ē	Peges ent of nt: if i		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Rose Hill Cemetery  7, 2007  Hagerstown,											Maruland	
Бапппог	pertm porter y intu		21. Signature of Funeral							ss of Facility	Minnich	Fun	eral Hom	e	
Ď	permi Depe impo eny ir		1 tru	d L.V.	estal		4	15 E	. W11	son Blv	1., Hage	rsto	wn, Mary	land 21740	
	Pnysician /Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)	lure. List only o	a	a consequ	Meh			Becok				Approximate Interval Between Onset and Death	
,00/80	w requires that the death certificate be executed been signed by the attending physician end should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):												
×	requires thet the death certific een signed by the attending p nould be detached for use as	by Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1										23d. Date of deliving Month	ery Day Year	
αs, r	uires thet signed b Id be deta	d by PI	Part II. Other significan	t conditions co	ontributing to death b	out not resu	ulting in the u	inderlying	cause giv	en in Part I.			^	he cause of death?	
ည	a % C	Completed									24a. Wa auto per	s an opsy formed?	24b. Were auto prior to co death?	opsy findings available impletion of cause of	
		ပိ	25. Was case referred to	o medical						00 Division 1 Division	1 ☐ Yes	2 🖬 N		2 No	
5	Physician: this certific ral director,	0 B	examiner?	-	Hospital:	ent 2 🗆	EB/Outpatier	nt 3 🗆 [	Oth	20	Home 5 200		6 Other /Spec	6.1	
	fing Ph	-	27. Manner of Death	Pending investigation	28a. Date of Injury (Month, Day Year)  28b. Time of Injury			11 00 00x   4   110 0 m g 1 m		28d. Describe			97		
DIVISION		Certification:		Could not be determined	288. Place of in	28e. Place of Injury - At home, farm, street, factory, office 28f. I					28f. Location City or To	(Street a	nd Number or Rur le)	al Route Number,	
	ne Hospital or n 24 hours efte ne Funerel Dir pletely filled in	Medical	29a. Certifier 1 (Check only one)	Certifying Ph Medical Exam	ysician: To the best niner: On the basis o and manner st	of examinat	wledge, deat tion and/or in	h occurre vestigation	d at the tir on, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time	e cause(: e, date ar	s) and manner as s nd place, and due t	stated. o the cause(s)	
	To the vithin To the compl	Σ	29b. Signature and title	of certifier				2	9c. Licens				ate signed (Month,		
			hurs	hack of	. onn	ems	- MG		0	41667	)		11.5.0	7	
ń	-6-1		30. Name and address	/	1. 0 0		1	Print)	^	00 /5	1		14	. 1	
וע			31. Date filed (Month, D	ax Year)	32. Registr	Mc (		1111	0	Medle	al Con	roup	Waser	stown MD	
	Sta Registr		A.	gy U 6 2	007	_ July 10	y	1 200	1						

	1 - State Registrar		Cei	rtificate of	Death		g. No.	007	20051
sician edical	1. Decedent's Name (First, Middle, Last) Michael C. Jack	son Sr.				2. Date of Death Month	Day 26	Year ZUO7	3. Jm Dof Death 1
miner	4a. Facility Name (If not institution, give s				r Location of Dea	th		nty of Death	
eral	Union Memorial  5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)		If Under 24 Hrs	8. Date of Birth	N/A  9. Birthplace (State or Foreign)		
tor	217-74-7920 1X	M 2□F	46 Yrs.	Months Days	Hours Min	NOV 8	1°960	D.C	ntry)
	Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	ocation				1	0d. Inside City Limits
npleted by Funeral Director	Maryland Anne Ar	undel G	len Bu	rnie					1 □ Yes 2 ☑ No
Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen o	of What Coun	ntry?
	7669 Rona Ct. A	pt A		2106	1		USA		
Funeral	Tr. Mantar States	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ace - Americ lack, White,	
by F	Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 █ No If Yes, Give Year or Dates:		1⊡Yes 2√∑No	Specify:		Spec	cify: Bla	ack
ted	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occup	oation	1	6b. Kind of	Business/Inc	dustry
Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of wo d)	orking			
Be Con	11th	00	L	aborer	40.14 % 1.15			Emplo	oyed
Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M		ame)	
T	Clayton Jackson  19a. Informant's Name/Relationship (Type)	pe. Print)	19b. Mailir	ng Address (Street		ce Cromwo		vn, State, Zip	Code)
	Janika Jackson(			-		A Glen	•		ŕ
3	20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ R	20b	. Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce)	Date 2	Oc. Location	n - City or To	own, State
.   ;	1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)			remator		-30-07	Balti	more	, Md.
ouce.	21. Signature of Funeral Service License  Yavy H. Reo					ns Mortua nnapolis			01
×.	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de ne cause on each line.	ath. Do not ent	ter the mode of dyi	ng, such as cardia	ac or respiratory arre	st,		Approximate Interval Between Onset and Death
1	Immediate Cause (Final disease or condition resulting in death)	Enupha							Jaka いろう
al er	resulting in deality	Due to (or as a conse							
e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse		4					UNKNOWN
Examine	Cause. Enter University Cause (Disease or injury that initiated events	AIDS							Unknown
EX	resulting in death) Last	Due to (or as a conse	equence of):						
dical		l							
- 0	IF FEMALE:	3c. If yes, outcome pf preg	inancy				224	Date of delive	
sician/M	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \) 2 \( \subseteq No \)	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	etal death 3	Ectopic pregnance Other (specify)	у			Date of delive Month	Day Year
Physi	9 Unknown	9□Unknown							
by P	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause giv	ven in Part I.				he cause of death?
						1 ☐ Ye	s 2 □ No	3 □ Prob	pably 4 ∰Unknow
Completed						24a. Was ar autopsy	/	prior to co	ppsy findings availabl mpletion of cause of
							No	death? 1 ☐ Yes	2 No
o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2	☐ ER/Outpatier	ot all DOA Oth		eath (Check only one			
	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	Home 5 Reside			<u>'y)</u>
atioi	1- Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		rk? ]Yes 2∐No				
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		28f. Location (Str City or Town	eet and Nu , State)	mber or Rura	al Route Number,
edical C		sician: To the best of my k ner: On the basis of exami and manner stated.							
₹	29b. Signature and title of pertifier	2		29c. Licens			_	ned (Month,	
	> Myso-10	eO,		ATZ	43894	16 HZ C	ctobes	26	,2007
	30. Name and address of person who co	empleted cause of death (It	em 23a) (Type,	Print)		16 HZ C	i		

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

toas cas

36655

6

Year

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No

Physician
/Medical
Examiner

KENNETH KEENEY 2. Date of Death Month OCTOBER

3. Time of Death

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show Director ns 23a or 7 Funeral r than "natural", or iten the Medical Examiner þ Completed 7 is marked other traumatic event, Be ဥ

permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

**Physician** /Medical **Examiner** 

Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Physician/Medical attending | as signed by the a Completed by funeral director Be ٩ Medical Certification: within 24 hours after death

To the Funeral Director: / the Hospitai

Division or Vital Records, P.O. Box 68760.

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SILAND HEND JEGUURA BUUL BALT'IHORE - WASHINGTON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months Hours 92 213-05-0154 Sep 11, 1915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Severna Park 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 43 West McKinsey Road, Apt. 123 21146 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Government Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alverta Mae Eyler Oliver C. Keeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code), MD 19a. Informant's Name/Relationship (Type. Print) 43 West McKinsey Road, Apt. 123, Pearl M. Keeney/ Wife 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of June al Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 12 Roun HEHORPHAGIC STROKE Due to (or as a consequence of): JO YEARS Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HALEK LEHRION Due to or as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AituaHad 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25.	. Was case referred to medica
	examiner?
	1 ☐ Yes 2 ☐ No

27. Manner of Death 1 FGNatural 5 ☐ Pending investigation 2 ☐ Accident

6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year)

1 npatient

28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

rmea? 2∐No

28d. Describe how injury occurred

24a. Was an autopsy perform 1∐ Yes 2

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

29b. Signature and title of certifier

29a. Certifier

D00CJ11A

29c. License number

29d. Date signed (Month, Day, Year) FOOL CALABOTOO

De Childrens Jes Chingbers 40

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO JOSE CIANCRECO

301 HOSPITAL BRIVE, GLEN BURDIE, HD 20161-5803

26. Place of Death (Check only one)

State Registrar

31. Date filed (Month, Day, Year) OCT 3 0 2007 32. Redistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State of Maryland State Registrer	Certificate of Death	Mental Hygien Reg. N	0.000
	ysicia		1. Decedent's Name (First, Middle, Last) Teresa Levy		2. Date of Death Month October 2	2007 3.3 6 6 5 6 7 2007 06:50 A M
Control of the Contro	/ledic amin	_	4a. Facility Name (If not institution, give street and number)  Mandrin Chesapeake Hospice House	4b. City, Town, or Location of Dear Harwood		c. County of Death Anne Arundel
Fun Dire			5. Social Security Number 6. Sex 1 → M 2 M F 7. Age (In yrs. In 1 → M 2 M F 55	Ast birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign Country) Washington, D.C.
1715-0036 within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show	otified at	Director		n, Town or Location apolis	100.0	10d. Inside City Limits 1 □ Yes 2 No Sitizen of What Country?
th with 23a or	ust be n	ral Dir	361 Friar Trail	21401	Unit	ted States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show	Examiner m	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.3  Armed Forces?  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	S. 13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
Baltimore, Maryland 21215-0036  Department of Health and Amrial Hygiene.  mportant: If Item 27 is marked other than "natural"; or	the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)  Clothing Designer	prking	Kind of Business/Industry
aryland 21 should be filed w and Mental Hygie	atic event,	To Be C	17. Father's Name (First, Middle, Last) Ralph David White	18. Mother's Na Nancy Rt	me (First, Middle, Maide uth Kline	,
Mar and 2 sh alth and 27 is m	er traum	,	19a. Informant's Name/Relationship (Type. Print) Camille W. Kalb/Sister	19b. Mailing Address (Street and Number or F		
nore, ages 1 g ant of He t: If Item	y or oth	1		lace of Disposition (Name of emetery, crematory or other place) as Crematory 10/2	. 1	Location - City or Town, State gewater, Maryland
Baltimore, Maperer, Mapermit. Pages 1 and 2 Department of Health s Important: If Item 27 is	any Injur once,		21. Signature of rvice-ticensee	22. Name and Address of Facility General Solomons Isla	eorge P. Kal	las Funeral Home
Physic /Med	100		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequ	cancer	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Exami		iner	Sequentially list conditions, if any, leading to immediate cause. List fund thing Cause (Disease or injury that initiated events	uence of):		-
68760, rificate be executed to physician and	he burial-tran	edical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last  C. Due to (or as a consequence of the consequence of t	zence of):		
, P.O. Box 68 that the death certificated by the attending pl	or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	I death 3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
IS, Prires that	be deta	þ	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.		o use contribute to the cause of death?
يّ ه ٣	page 2 should	ompleted			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
or Vital F Physician: Th	ector,	o Be C	25. Was case referred to medical examiner?  1   Yes   2   No	Other:	eath (Check only one)	Hospice 6XOther (SpecifyHouse
and and	neral	ertification: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At ho	28b. Time of Injury Mark Work?  M 1 Yes 2 No	28d. Describe how in	
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	illed in b	OF	4 Homicide determined building, etc. (Specify		City or Town, Sta	ite)
To the Hosp within 24 ho To the Fund	ipletely f	ledical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my know 2 Medical Examiner: On the basis of examinar and manner stated.	tion and/or investigation, in my opinion, death occ	curred at the time, date a	and place, and due to the cause(s)
Tovit	000	Z	29b. Signature and title of certifier	29c. License number P65272	29d. C	Pate signed (Month, Day, Year)
1	1 W		30. Name and address of person who completed cause of death (Item Jason Taksey, M.D., 900 Bestgat	e Road, Suite 300, Ann	apolis, Mar	yland 21401
Re	Sta gistr		31. Date filed (Month, Day, Year)  OCT 3 0 2007	K. Annel .		
DHMH 17 R	ev 1/2	001		ORIGINAL		

State of Maryland / Department of Health and Mental Hygiens, 36657 Certificate of Death 3. Time of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month Yee Physician 2007 17:15 PM Nov. 6 /Medical Dorothy Elizabeth Miller 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner WMHS Braddock Campus Cumberland Allegany If Linder 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) Funeral Months 1□ M 2₽F 82 Yrs. Director July 3, 1925 Maryland 215-36-8739 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heatth and Mantel Hygiene. Department of Heatth and Mantel Hygiene. Important: if I tem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examine must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 11☑ Yes 2□ No Frostburg Funeral Director MD Allegany 10g. Citizen of What Country? 10f Zip Code 10e. Street end Number 21532 United States Street 174 West Mechanic 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married SpecifyWhite Baltimore, Maryland 21215-0020 1□ Yes 2⊋No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) Registered Nurse Health Care 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marshall McKenzie Ruth Broadwater McKenzie 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) William Miller husband 174 West Mechanic St., Frostburg MD 21532

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

1 M Burial 2 D Cremation 3 D Removal from State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Frostburg Mem Park
22. Name and Address of Facility 11-9-2007 Frostburg, MD 21. Signature of Funeral Service Licensee Sowers Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Frostburg, MD 21532 Physician Due to (or as a obnsequence of): /Medical Immediate Ceuse (Final disease or condition resulting in death) town Examiner Physician/Medical Examiner or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) after deeth.

Director: After this certificate hes been signed by the a d in by the funerel director, page 2 should be datached f 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 V Yes 2 No edicai Certification: To 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Injury 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Frostoury Maryland 21532 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) a. D 4 Brokevay SATURNING 32 Registrer's Signature 31. Dete filed (Month, Dey, Year) State NOV 15 At Spilled Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08615 State of Maryland / Department of Health and Mental Hygiene Robert A Matthews Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2007 2320 hrs Mathews, II Anthony Medical Examiner Robert 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Allegany Cumberland Western Maryland Health System If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Maryland Months Days Hours 06/18/1982 Country) 220-11-2665 Director 25 1XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 'n Yes 2 X No s 23a or 28a-f show e notified at once. Corriganville MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21524 12708 Old Hollow Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. , or items 2 r must be r If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 2 X No Yes Yes 2 X No specify: Specify If Yes, Give Year Widowed 4 Divorced White other than "natural", the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) be filed within 72 l Television Cable Installer 2 21215-0036 12 of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Costadile Mathews Bambi Lvnn Anthony Robert item 27 is marked Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Pages 1 and 2 should ို 316 Furnace Street, Cumberland, MD Robert A. Mathews / Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State St. Patrick's Cemetery 11/9/2007 Cumberland, MD Donation 5 Other Specify. 22. Name and Address of Facility Adams Family Funeral Home, Signeture of Funeral Service Lic 404 Decatur Street, Cumberland, MD 21502 oter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death /Mudical a. Methadone intoxication complicating acute exacerbation of asthma Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause du, (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi sician/Medical XUNPENDED .27,28a-f. perME.g873, 11/19/07 TT Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown þ σ. Completed 24b. Were autopsy findings available Records, 24a. Was an peen prior to completion of cause of autopsy performed? death? certificate has No ✓ Yes 2 1 🗸 Yes page 26 Place of Death (Check only one) 25. Was case referred to medical Be of Vital Other<sub>4</sub> examiner? Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27 Manner of Death 1 Yes 2 X No Natural Division Pending death. Director the 11/5/2007 10:15 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by X Could not be 3 Suicide or Town, State)
12708 Old Hollow Rd. Corrganville, MD determined (Specify) single family residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely g 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. November 6, 2007 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carpl Allan, MD 32 Registrar's Signature State 2007 Registra

DHMH 17 Rev 1/2001 OCME 2006

DCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician ам Frederick William Mitschele October 27, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Village Montgomery Village Health Care Center Birthplace (State or Foreign Country)

New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F 095-05-1339 93 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shovidical Examiner must be notified at XXYes 2 No Director Maryland Chevy Chase Montgomery 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 20815 IISA 4615 N. Park Avenue, Apt. 214 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give 1941–46 Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commercial Bookbinder Graphic Arts marked other Jith and Mental Hv. 7 is mark. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Paul Mitschele Mary Elizabeth Morio ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun 4615 North Park Avenue, Apt. 214, Chevy Chase, MD 20815 Mary Ruth Edwards/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 5 1 2 Burial 2 ☐ Cremation 3 □Removal from State Quantico Nat'l Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Triangle. Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 0 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Hypernatrenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed Acute Renal Failure burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown icale has leen sig Anemia, Hypertension, Prostate Cancer Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1□ Yes 2**X**No Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 29, 2007 D41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, MD 10301 Georgia Avenue, #203, Silver Spring, MD 20902 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year 4:00 A M /Medical Oc. 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours 1 M 2 YE Yrs. Director 087-28-9708 89 JUNE 7, 1918 **ENGLAND** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XYes 2□No Director MONTGOMERY MD. **GAITHERSBURG** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 SUNNY BROOK TERR. APT.#912 20877 Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No <u>^</u> 3 ₩ Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F is marked ot Pages 1 and 2 should be **EDWARD** ပ NEIL **ELIZABETH** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20877 Health a NEIL McGUIRE/SON 504 SUNNY BROOK TERR. APT. #912, GAITHERSBURG, altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 10-30-2007 RIVERDALE, MD. 21. Signature of Funeral Service Lices 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Endocardit disease or condition resulting in death) day /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the ass use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐ Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) 1 Yes 2 No Hospital: ipital: 1 Inpatient 28a. Date of Injury Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29b. Signature and title of certifile

3

State Registrar Brandon

31. Date filed (Menth Day, Year)

Falk

Medica

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

9901

32. Registrar's Signature

D0064029

٦7.	083	15
,,		

07-08315	Please Type or Print in Black Indelible Ink. Ensure All Copies Are L	egible.		
Sean Patrick McMahon	State of Maryland / Department of Health and Mental Hygiene		2007	38
1- For State Registrar	Certificate of Death	Reg. No.	2001	

n Patrick Mc		1- For State	ate of Maryla	nd / Depa		f Health			ygiene		200.	7 36661
Physicia dical Exami	ın/	Registrar 1. Decedent's Name (First, Middle Sean Patrick M							2. Date of Death Month October 26		Year	3. Time of Death 0039 hrs
aicai Examii	ler	4a. Facility Name (if not institution		mber)		4b. City, To	vn, or Locat	tion of Death		4c. Cour	nty of Death	00001113
		6661 Harbor Light Wa	·			New M			la p v tp m	Frede		halas (Chah
Funeral Director		5. Social Security Number 218-19-6053	6. Sex	7. Age (In yrs. I	ast birthday) 30 Yi	If Under Months		Under 24Hrs Iours Min	_	,		hplace (State or Washington,
	ŀ	Usual Residence of Decedent	Lac. L				<u> </u>		03/20/	17//		DC
d now any		10a. State 10b. County  Maryland Fred	erick	10c. City,	Town or Loca	Market						10d. Inside City Limits  1 Yes 2 X No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	erick		116 M	10f. Zip C	ode		10	g. Citizen of	f What Cour	try?
th the N 23a or notified	إة	6661 Harbor Li			- T		774	0:::0/0			d Sta	
eath wi	Funeral	11. Marital Status  1 Never Married 2 X		edent Ever in U orces? 2 XX No		Yes, specify			pecify Yes or No- Rican, etc.)		Race - Ameri Vhite, etc.	can Indian, Black,
after d ral", or	by Ft		orced If Yes, Give Yea or Dates:	r	1	Yes 2 X				Spec		
2 hours "natu	eted	<ol> <li>Decedent's Education (Spe- Elementary/Secondary (0-12)</li> </ol>				ent's Usual O most of worki				16b. Kind o	of Business/I	ndustry
vithin 7	Completed		4		Softwa	are An						n Technology
215-( e filed v tal Hygi ked oth nt, the	Be Co	17. Father's Name (First, Middle, Stephen McMaho							e (First, Middle, M :Mullan	laiden Surna	ame)	-
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relations Donna McMahon							Rural Route Num			
e, MI 1 and 2 Health 2 item 27		20a. Method of Disposition			Place of Disp	osition (Name		у,	Date			Town, State
mor Pages nent of ant: If or other		1 Burial 2 XX Cremation 4 Donation 5 Other S	pecify:	om State	crematory or o	n Crem	atory		2007	Frede	erick,	Maryland
Balti permit. Departu Import		21. Signature of Juneral Bervice	Licensee		22 R	Name and A	ddress of F en Fui	acility nera1	Services	s, Skk	ot Co	dy P.A.
Physician		23a. Part I. Enter the disease, of failure. List only one cause	complications that c	aused the death	n. Do not enter	the mode of	toct1 dying, such	n Mtn. nas cardiac	Hwy F	rederi est, shock, o	r heart	Approximate Interval Between Onset and
/Medical :xaminer		Immediate Cause (Final dispase or condition resulting in death)	a. Hanging									Death
		Sequentially list conditions,	b.	consequence of	or):							
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated										
ted J nnsit		events resulting in death) Last	Due to (or as a	consequence of	of):							
e executed cian and irial - transi	dical	UNPENDED	AMENDED					-				
8760 ifficate b	sician/Me	IF FEMALE: 23b. Was decedent pregnant in t		outcome of preg		Fetal death	3 E	ctopic pregn	ancy	23d. Da Mon	ite of deliver	y Day Year
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	sicia	past 12 months?		ant at time of d		Other (Speci	fy)					
O. Bat the de de de by the trached	/ Phy	Part II. Other significant condi		o death but not	resulting in the	e underlying (	cause given	in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
S, P.O. puires that the substitution of the signed by all the detack	ed by								1 Yes			bably 4 Unknown
ing Physician: The law require Physician: The law require After this certificate has been simmeral director, page 2 should be	Completed						_		autop	rmed?	prior to death?	completion of cause of
I Re		25. Was case referred to medical	al			2		Death (Check	1 Yes	2 No	1 🗸 Y	es 2 No
Vita	To Be	examiner?  1 ✓ Yes 2 No		Inpatient 2	ER/Outpatie				ing Home 5		6 🗸 Othe	er: Scene
ion of V tending Phyeath. tor: After the funeral	tion:		Uning 10-400	), Day,Year)	FOUND:	of injury 2	3c. Injury at	2 No	28d. Describe Subject han		ccurrea	
Division tal or Attendiners after death.	Certification	3 ✓ Suicide 6 Cou	id not be	ce of Injury - At I	0039 hrs nome, farm, st	reet, factory,	office buildi	ng, etc.	28f. Location (S		lumber or R	ural Route Number, City
Ospital hours a		29a. Certifier	hysician: To the be	Single Fa		curred at the	ime date a	ind place, ar	6661 Harbor I	Light Way,		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be deached for use as the buin	Medical	(Check only one) 2 Medical Exa	aminer: On the basis and manner:	of examination	and/or investi	gation, in my	opinion, dea	ath occurred	at the time, date	and place, a	and due to the	ne cause(s)
F 2 F 0	ğ	29b. Signature and title of certifi	er of on	00-		29c.	O.C.M.E				signed (Mo er 26, 200	onth, Day, Year)
10		30. Name and address of person	n who completed cau	se of death (Ite	m 23a)		J. J. 191. L					·
10		Carol Allan, MD As	ssistant Medical	Examiner	111 Peni	n Street, E	altimore	, MD 212	01			
S	tate	31. Date filed (Month, Day Year)	9 32. R	sistrar's Signa	ture	Land 1						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 26 2<sup>Year</sup> 27 Month 3:10P M October Yvonne McNeill 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel 112 Dogwood Rd. Annapolis 8. Date of Birth NOV 18 1936 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Min. Months Days Hours Maryland 1 □ M 2 🗓 F 70 218-32-6761 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 No Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21403 112 Dogwood Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify. 3√Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk JC Penny 0 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Johnson Frank Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 933 Sedgley Rd. Catonsville, Md. 21228 Glendora Holland(Niece) 20b. Place of Disposition (Name of Demoter), Grandtory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11-2-07 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Winjame Receise of EaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 100483 eese ann Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 404-5 2+0.5 Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? onditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

and

physician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or Items 23a or the Medical Examiner must be

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other I any Injury or other traumatic event, <u>th</u>

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

death with the Maryland

Examiner burial-transit Physician/Medical the ed by the attending detached for use as signed by funeral director.

Hospital or Attending Physlcian: The law requires that the death certificate be executed

this

After t

24 hours after death. e Funeral Director: A

To the within 24

filled in by

completely

Medical

Division or Vital Records, P.O. Box 68760,

dical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
ıysician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 ☑No 9 □ Unknown
Certification: To Be Completed by Physician/Medical Examin	Part II. Other significant or Deen Ven
ro Be	25. Was case referred to mexaminer? 1 ☐ Yes 2 ☑ No
Certification:	27. Manner of Death  1/∰ Natural 5 ☐ F  2 ☐ Accident ii  3 ☐ Suicide 6 ☐ 0  4 ☐ Homicide

49live

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANION

rar's Signature

32. Regintr

1 homas

3 0 2007

24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No 1 ☐ Yes 2 No 1□ Yes 26. Place of Death (Check only one) edical Other: 4 Nursing Home 5 Residence 6 DOther (Specify) Hospice 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide determined 4 Thomicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

D0036242

137 mitabrell's Change RD, Edgewater, MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1315 pm Physician 2007 5 November Luther Wilbert NAYLOR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Funeral Months Days Hours 1 M 2 □ F 91 Nov. 23 1915 Virginia Director 180-16-5726 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 USA 10116 Sharpsburg Pike Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Expeditor Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lelia Susan Madison Luther Wamsley Naylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 17145 W. Washington Street, Hagerstown, Md. 21740 Norman L. Naylor - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 11/8/07 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Waleut & Rocker 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YZAKS disease or condition resulting in death) GHRONIC OBSTRUCTIVE POLMONARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 Yes 2 No 3 Probably 4 Unknown C PACINOMA PUL MOM TRY Completed NEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performed? 2 -NO 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

physician s the burial Box 68760 þe as for use P.O. is been signed by the should be detached Division or Vital Records, page 2 s or Attending Physician;

death.

Hospital

341-4

ral", or items 23a or 28a-f show Examiner must be notified at

the Medical

than

1 and 2 should be filed w Health and Mental Hygie om 27 is marked other ti

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai

within 72 hours after death with "natural", or items 23a

Baltimore, Maryland 21215-0036

burial-transit director Certification: To After this funeral ours after death.

neral Director: A
filled in by the fu within 24 hours a To the Funeral C

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number P0001040 11-06-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

322 E. ANTIETMY ST, HAGERS DUN, MD 21740 COHEN

State Registrar

Medical

31. Date filed (Month, Day, Year) 0 32. Registrar's Signature

Мε

David Lynnwood Naylor

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend #31 per FCHD 10-30er2160cate of Death CNM

2007 36664

3. Time of Death

Reg. No.

OCME

2. Date of Death Decedent's Name (First, Middle,Last) Month Day October 26, 2007 hysician/ LYNNWOOD NAYLOR 1935 hrs DAVID Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick 406 Broadway Street 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number oreign **Funeral** Country) MD. Months Days Hours 23 DCT. 60 ٧r٩ Directo 219-44-4677 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 No FREDERICK FREDERICK MB 23a or 28a-f show notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country Director 10e. Street and Number U.S. A 21701 BROADWAY 406 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11, Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married Married Specify: BLACK Yes Yes 2 No specify: Ves Give Yea Divorced Widowed 16b. Kind of Business/Industry ş 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) CONSTRUCTION Completed Elementary/Secondary (0-12) MAKER CABINET 21215-0036 12 TH 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) THOMAS E. NAYLOR NETTIE OVERS Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 i 70 3 19a, Informant's Name/Relationship (Type, Print ) (DAU) OLEANDER PL. Unit A FREDERICE MO 5803 PANNELL MICHELLE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition NOV. 1, 2007 SMINISIBURG MD. Baltimore, crematory or other place) Removal from State Burial 2 / Cremation 3 CREM. L. ROLLINS FIN. HOME Donation 5 Other Specify: 21. Signature of Funeral Service License FREDERICK MD 21701 SOUTH ST olleis a. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and ysician Death failure. List only one cause on each line a. Atherosclerotic Cardiovascular Disease /Medical Immediate Cause (Final disease Examiner Due to (or as a consequence of): condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit the death certificate be executed Physician/Medical AMENDED ysician a burial -UNPENDED 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy e attending physical for use as the bu IF FEMALE Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death 2 detached for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Fo the Hospital or Attending Physician: The law requires that þ Chronic Ethanolism 24b. Were autopsy findings available 24a. Was an Completed After this certificate has been s funeral director, page 2 should prior to completion of cause of autopsy performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Residence 6 V Other: Scene Be Nursing Home 5 Hospital: 1 ER/Outpatient 3 Inpatient 2 No 1 ✔ Yes ٩ 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No 1 V Natura Pending Director: within 24 hours after death 28f. Location (Street and Number or Rural Route Number, City Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. Accident or Town, State) Could not be 3 Suicide determined e Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 27, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Mooth Day Year) State T LUUI Olow

	Please	Type or Prin	t in Black Ir	idelible Ink	k. Ensure	All Copies	s Are L	_egible.	
	. For	State of Ma	ryland / Dep	artment of	Health and	Mental Hy	/giene	2007	36665
	1 - State Registrar		Ce	rtificate of	Death		Reg. No.	2001	30000
Dhysisian	1. Decedent's Name (First, Middle, La.	st)			•	2. Date of D Month	eath Day	Year	3. Time of Death
Physician /Medical	Thomas Josep	oh O'Donnel	1, III			Oct.			5:20 <sup>а.м.</sup>
Examiner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Dea	th	4c. (	County of Death	
	Brighton Gar			Bethes				Montgome	
Funeral Director	5. Social Security Number  578-34-5038  Usual Residence of Decedent	ex 7. Age ⊠M 2□F	(In yrs. last birthday 78	Months Days			ay, Year)	Cou	place (State or Foreign ntry) XAS
laryland show ed at	10a. State 10b. County		10c. City, Town or L	ocation ethesda					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
vith the Mar a or 28a-f sl be notified Director	Md. Montgome	=1 y		10f. Zip Code			10a Citia	zen of What Cou	
th with t	5301 Westbard Cir	rcle #340			816		Tog. Oniz	USA	nuy?
r items 23a iner must Funeral	11. Marital Status 1 □ Never Married 2 △ Married	12. Was Decedent E Armed Forces? 1 XYes 2 N	ver in U.S. 13.		Hispanic Origin? ( Iban, Mexican, Pue	Specify Yes or N erto Rican, etc.)	0- 1	<ol> <li>Race - Americal Black, White,</li> </ol>	
hours a tural", o al Exam	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1952	1 ☐ Yes 2 ☐ No edent's Usual Occi				Specify: Wand of Business/Ir	hite
"nar edica	15. Decedent's Ed (Specify only highest gra	ade completed)	(Giv	e kind of work don DO NOT use retir	e during most of w red)	orking	100. Kii	id of business/ii	ldustry
ed within 72 hor ygiene. her than "natura her the Medical E ft, the Medical E	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Employed			1	Estate	Broker
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last,		-			me (First, Middle M. Fox	e, Maiden i	Surname)	
short and N is ma	19a. Informant's Name/Relationship (	Type. Print)	1	-	et and Number or F				
and sealth	Joan Nolan O'Don	nell/Wife	<del></del>		d Circle				
Jes 1 of Hi or oth	20a. Method of Disposition 1   Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pl		Date	20c. Loc	cation - City or T	own, State
tment tant: jury o	4 □ Donation 5 □ Other (Specif	y)		et Cemet		.3,2007	1	hington	, D.C.
permit Depar Impor any In once.	21. Signature of Funeral Service Lines	nse#			ress of Facility D				D.C. 20007
1000	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plica ons that caused to	the death. Do not er						Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. Pancre	atic_Canc	er					Onset and Death Months
Examiner		Due to (or as a	consequence of):						
executed in and fal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
be executed sloian and burial-transit	that initiated events resulting in death) Last C Due to (or as a consequence of):								
ificate be g physicia as the bur		d							
The law requires that the death certificate to the has been signed by the attending physicage 2 should be detached for use as the tompleted by Physician/Medicalompleted by Physician/Medicalompleted by Physician/Medicalom	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnan			2	23d. Date of delive	very Day Year
that ned by deta		contributing to death bu	t not resulting in the	underlying cause g	jiven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
w requires that she been signed to should be detailed by Please by						. 10	Yes 2	No 3 Pro	obably 4∏Unknown
sician: The law requi certificate has been s irector, page 2 should	-					per	opsy form <u>ed</u> ?	prior to co death?	opsy findings available ompletion of cause of
ifficati				<del> </del>	26 Place of D	1  Yes eath (Check only		1 ∐Yes	2 □ No
ysician s certif director	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	ent 3 DOA	thor:	Home 5 ☐ Res		S □Other (Spec	if <sub>t</sub> ()
g Phy er this eral d	- II I I	28a. Date of Injury	y 28b. Time			28d. Describe			19)
ath. or: Aftu ne fun	1 ☑ Natural 5 ☐ Pending investigation		Year) Injury		□Yes 2□No				
ital or Attending F rs after death. al Director: After led in by the funera	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ry - At home, farm, s (Specify)	treet, factory, office	е		(Street and own, State)		ral Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I Medical Certification: To Be C		nysician: To the best o	examination and/or						
ithin 2 or the ormple	29b. Signature and title of certifier	and manner stat		29c. Licer	nse number		29d. Date	e signed (Month	, Day, Year)
F 3 F ŏ	11/1/	1. 1.			00057		_		0.0.0.

20

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 😂

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

D33357

Jonathan Musher, M.D.,5530 Wisconsin Ave., Suite 1045, Chevy Chase, Md.20815

Month Day, Year) 32 Registrar's Signature

Oct. 29, 2007

			For State AMEND#10ame					rtment of H		d Ment	al Hyg	jiene			
			State Registrar FIND#19ape		, אנייבו, 77		Cer	tificate of L	<i>Jeain</i>	2. Di	ate of Dea	eg. No. 2	007	355556 3. Time of Beath	$\neg$
	Physicia		,	e Pollock						M	onth ober	Day 30	Year 2007	6:16 aM	
	/Medic		4a. Facility Name (If not instituti	on, give street an	d number)			4b. City, Town, or	Location of De	eath		4c. Cou	nty of Death	L	1
			Casey House/Mon	,					kville				Montgom		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🗵		e (In yrs. lasi	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	vin. (A	ate of Birth fonth, Day	, Year)	Coun		
	Director		224-54-6045 Usual Residence of Decedent			66				Aug	ust 24	, 1941	Nor.th	Carolina	$\dashv$
yland	at		10a. State 10b. Count	у		10c. City, T	Town or Lo	cation					1	0d. Inside City Limits	
e Mai	3a-f s	Director	Maryland Mon	tgomery					r Spring	g				1 ☐ Yes 2 🖾 No	_
vith th	or 28		10e. Street and Number					10f. Zip Code			1	l0g. Citizen	of What Cour	-	
eath v	ns 23a must	Funeral	14908 C1a		Decedent	Ever in U.S.	13. V	Vas Decedent of Hi	20905	? (Specify )	es or No-	14. F	U.S.A Race - Americ		-
o uffer d	r iter		1 ☐ Never Married 2 ☐ Ma	rried Armo	ed Forces? Yes 2⊠1			Was Decedent of Hi f Yes, specify Cuba		uèrto Rican	, etc.)		Black, White,	etc.	
OCC Sours	ral", o Exan	j by	3 ☑ Widowed 4 ☐ Divorce	d Year	s, Give or Dates:			I□Yes 2⊠No	Specify:				cify:	White	
172 h	"natu edical	Completed	15. Decede (Specify only high	nt's Education est grade comple	eted)	1	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	luring most of	working		16b. Kind of	f Business/Ind	dustry	4
with <b>Z</b>	than	dmc	Elementary/Secondary (0-12)	Colle	ege (1-4or 5 1	i+)	me. L	Realt				Re	eal Esta	ite	
d filed	Hygi other ent, t	0	17. Father's Name (First, Middle	e, Last)					18. Mother's	Name (Firs	t, Middle,	Maiden Surr	name)		
Viana uld be file	venta rrked tic ev	To B	Homer Trou	tman					I	Louise	Mulwee	2			
lar) 2 sho	and I	ľ	19a. Informant's Name/Relation	nship <i>(Type. Prin</i> LOCK	t)		19b. Mailin	ig Address (Street a	and Number o	or Rural Rou	ite Numbe	r, City or To	wn, State, Zip	Code)	
and and	lealth		Robert L. Pel 20a. Method of Disposition	<del>lack</del> - Sor	1	20h Plac		Lakewood Dr sition (Name of	ive, Lug	goff, S	South (		a 29078 on - City or To	own State	_
ages .	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☑ Cremation		from State	cem	netery, cren	natory or other plac	1	0/31/20	307		wood, Ma		
<b>Daltimo</b> bermit. Pages	artme ortani injury		4 ☐ Donation 5 ☐ Other  21. Signature of Funeral Service			Ft.	22	In Crematory  Name and Addres	s of Facility				wood, M	ar y ranu	
De L	Depar Impor any ir once.		1 (mand	a Li	dec	UM		ines-Rinald 1800 New Ha					ing, Mar	yland 20904	1
	trad Sect.		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications st only one cause	that caused on each lin	the weath.	Do not ent	er the mode of dyin	g, such as car	rdiac or res	piratory arı	rest,		Approximate Interval Between	
Ph	ysician		Immediate Cause (Final disease or condition	a.				r of Lung						Onset and Death	
	Medical kaminer		resulting in death)	Di	ue to (or as	a consequer	nce of):								
		-er	Sequentially list conditions, if any, leading to immediate	b	ue to (or as	a consequer	nce of):								_
uted	ansit	Examiner	cause. Enter Underlying Cause (Disease of Injury that initiated events	<b>5</b> .											
exec	an an irial-tr	Еха	resulting in death) Last	D	ue to (or as	a consequer	nce of):								_
od / ou, icate be executed	physician and the burial-transit	dical		d											_
	ding p		IF FEMALE:	23c If ve	s. outcome	pf pregnanc	ev					224	Date of delive	an/	1
death certif	been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	10	Live birth	2 ☐ Fetal de t time of dea	eath 3	Ectopic pregnancy Other (specify)				200.	Month	Day Year	
Ę Ç	oy the ached	hysi	9 ☐ Unknown	9□	Unknown										_
Ords, P	gned l	by P	Part II. Other significant cond	tions contributing	g to death b	ut not resulti	ng in the u	nderlying cause give	en in Part I.					he cause of death?	
COLO	en si					<u> </u>				_	1 📙 Y	′es 2∐N	o 3∐Prol	bably 4⊠Unknown	_
<u>¤</u> &	has be e 2 sh	Completed									24a. Was autop		4b. Were auto prior to co death?	opsy findings available impletion of cause of	
<u> </u>	icate l										1□ Yes	2K No	1 ☐ Yes	2 ☐ No	
Or Vital Physician:	recto	o Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☒ No	Hospital:	1 □ Innatia	ent 2□EF	3/∩utnatier	ot 3 DOA Oth	26. Place of				Other (Speci	fy) Hospice	
o Phy	After this certificate has funeral director, page 2 s	⊢	27. Manner of Death		Date of Inju	iry 2	8b. Time of					now injury oc		y) Hospiec	
SION tending	ath. or: Aft he fun	atio	Z L Accident	stigation				M 1□	Yes 2 □ No						
UIVIS I or Att	ter de lirecto n by tl	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 28e.	Place of inj building, et	ury - At hom tc. <i>(Specify)</i>	e, farm, str	reet, factory, office			ocation (S City or Tow		umber or Run	al Route Number,	
Dital C	eral C		29a. Certifier 1 ☑ Certif	ing Physician:	To the best	of my knowle	edge, deat	h occurred at the tir	ne, date and r	place, and	due to the	cause(s) and	d manner as s	stated.	-
e Hos	e Fun	Medical		al Examiner: On		of examinatio		vestigation, in my o							
To th	within 24 hours after death.  To the Funeral Director: After it completely filled in by the funeral	Me	29b. Signature and title of certi	fier / 1, /	M	. ~		29c, Licens	e number			29d. Date si	gned (Month,	Day, Year)	
1	0		Menier	enhol		( W)		D00	064615			0ct	ober 30,	, 2007	_
			30. Name and address of person						D - 1 1 1 1	1 - 14	1	00050			
	Sta	ate.	Genevieve Anr 31. Date filed (Month, Day, Yea	ar)	32 Registr	rar's Signatu	re		KOCKV11	ie, Mai	yrand	20850			_
	Regist		OCT 3	2007	Benev	e K	(A)	ente							

			For State	State of Marylar	-						2007	00007
	-		Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtifica	te of Dea	itn	2. Date of De		2007	36567
	Physici		Ilse Wilhelmine Pi	erkes					Month	Day		4:50 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give sa			4b. City	, Town, or Locat	tion of Death	occope.		County of Death	1 4.30 A
			15107 Interlachen			Į.	ver Spr	_		Мо	ntgomery	7
S. St.	Funeral Director		5. Social Security Number 6. Sex 1 $\square$	7. Age (In yrs.	V	If Unde Months		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Da	y, Year)	Cour	place (State or Foreign ntry) nany
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation					1	0d. Inside City Limits
	Maryli f sho ied at	tor	Maryland Montgomer	y Sil	ver Spi	ring						1 ☐ Yes 2X No
	h the or 28a	Director	10e. Street and Number			10f. Zi	p Code			10g. Citiz	en of What Cour	ntry?
	23a c ust b	ral	15107 Interlachen	Drive, #617			.0906				ited Sta	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 🛣 Widowed 4 □ Divorced	<ol> <li>Was Decedent Ever in U Armed Forces?</li> <li>1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:</li> </ol>		Was Dece If Yes, sp 1 ☐ Yes	edent of Hispanic edify Cuban, Me 212 No Spe	c Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: Wh:	etc.
21215-0036	2 hou natura ical E	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usi	ual Occupation	most of work	ina	16b. Kin	nd of Business/In	
2	ithin 7 ne. nan "r Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT	ork done during use retired)	most of work	ing			
2	iled willed will her ther ther ther there there is the contract the co		12 17. Father's Name (First, Middle, Last)		Sec	creta		Anthor's Nam	e (First, Middle	1	chine Sh	nop
Maryland	ould be f Mental H arked ot atlc ever	o Be	Hubert	Kratzb	orn		10.10	notici 3 ivaiii	Maria		immer	
ary	should Ind Men marke	10	19a. Informant's Name/Relationship (Typ			ng Addres	s (Street and No	umber or Rui			Town, State, Zip	Code)
	1 and 2 Health a tem 27 is		Mary Eileen Bonhag/					t, Sil	ver Spr	ing,	Marylan	d 20905
ore	Pages 1 nent of He int: If Iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		Place of Dispo cemetery, crei	sition (Na matory or	me of other place)		Date	20c. Loc	cation - City or To	own, State
altimore,	t. Pag rtment rtant: njury o		4 □ Donation 5 □ Other (Specify)	Met			Cremato					Virginia
Ba	permit. Pages Department of Important: If it any Injury or o		21. Simplure of Funeral Service License	1 1O.V			nd Address of F					D. 20877
2	900		23a. Part1. Enter the disease, or complic	cations that caused the dea							sburg, M	Approximate Interval Between
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Lung Cancer								Onset and Death  5 Months
	/Medical		resulting in death)	Due to (or as a consec	quence of):							J Months
2	Examiner	_	Sequentially list conditions, b.	Due to for an a consequent								
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence or):							
Ć,	execu n and lal-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):							
68760,	ficate be executed physician and the burlal-transit	dical	d.									
	ertifica ing ph e as th		IF FEMALE:									
.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	3c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of of 9 ☐ Unknown	aldeath 3	⊒Ectopic ¡ ⊒Other (s	pregnancy pecify)			2	3d. Date of delive Month	ery Day Year
<u>a</u>	s that ned by deta	by Ph	Part II. Other significant conditions conf	tributing to death but not res	sulting in the u	nderlying	cause given in F	Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?
g	w requires been signe should be								10	Yes 2	No 3€ Prol	pably 4 □Unknown
Vital Records,	e law re has be	Completed							24a. Was	psy		ppsy findings available impletion of cause of
<u>س</u>	: The cate ha	Соп							perfo 1⊟ Yes	ormed? 2 ☑ No	death?	2 No
<u>=</u>	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:			Other		h (Check only			-
o	y Phys er this eral di	1: To	1 ☐ Yes 2 🔀 No ""  27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		28c. Injury at Work?	_ Nursing Ho	me 5 KJ Resi 28d. Describe		☐Other (Special)	(y)
0	ath. rr: After	atior	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	м	work? 1 ☐ Yes	2 □ No				
Division or	Ital or Atters safter destal Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, str	eet, facto	ry, office		28f. Location ( City or To	Street and wn, State)	d Number or Rura	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical Co		ician: To the best of my knier: On the basis of examination and manner stated.								
	To the within To the comple	Me	29b. Signature and title of certifier	A 4		25	c. License num	ber		29d. Date	e signed (Month,	Day, Year)
)			* U·MW				D 2312	24		Oct	ober 30	, 2007
	20		30. Name and address of person who cor									
	04-	•	Dennis M. Hannon, M	I.D., 2901 01 3 Registrar's Sign	ney-Sai	ndy S	Spring R	kd., 01	Lney, Ma	aryla	ind 2083	
	Sta Registr		31. Date filed (Month, Day, Year) OCT 3 1 2007		4 Son	all )	-					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36668 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 6, 2007 3:50 A JOHN GORDON READMOND Nov. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) 5/1/1916 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 087-12-8191 Washington, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medi al Examiner must be notified at 1 ☐ Yes 2 No Director MD. Fallston Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō or items 23a Pleasantville Road 21047 2807 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Armed Forces?

1 Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 □ Widowed 4 N Divorced II White "natural", aryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Contract Administrator Radio & Radar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be William Readmond Blanche 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 John P. Readmond (Son) 316 Montgomery Drive Forest Hill, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of HIMportant: If ite any Injury or ot Carroll Cremation 11/9/07 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland Heckern E.G. Son Funeral Home. P.A. Kurtz & 23a. Part1. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each june. Immediate Cause (Final melinism 4HRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner as the burial-tran and Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) n signed by the at Id be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? ENTRAIN. 1 🗌 Yes 2 No 3 Probably 4 Onknown cate has been s , page 2 should should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Was a... autopsy performed? Yes 2 No 24a. Was an certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Thpatient 2 ER/Outpatient 3□ DOA P the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Offector: After Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year)
NO URIN LES BY 2007 nd title of certifier 29c. License number 29b. Signature

State Registrar

5

30. Name and address of person who completed cause of death (Item 2 a) (Type, Print)

32, Registrar's Signature

LANGE ARE

16444

602 S. Atwood Rd. Belan 21014, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Month **Physician** Thomas Orin Reynolds 29 Oct 12:10P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Brill OCCI, TS, 1945 Rhode Island Days 1**X** M 2□ F Hours Months 62 **Director** 557-64-0752 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ns 23a or 28a-f sh must be notified 1 □Yes XXNo Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2638 Midway Branch Dr #303 21113 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ı "natural", or itemi edical Examiner n Black, White, etc. 1 ☐ Never Married 2 ☑ Married XYes 2□No 1963 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by White Specify: Year or Dates: 3 Widowed 4 Divorced 1965 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Pipe Liner Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Sydney O. Reynolds Bernice Provost 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22405 19a. Informant's Name/Relationship (Type. Print) of Health item 27 I Audra Reynolds / Daughter 1219 Thomas Jefferson Pl, Fredericksburg, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Natl Cem Nov 6,07 Triangle, VA 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fredericksburg, VA22407 Found & Sons 10719 Courthouse Rd Mul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of) Examiner Paraplegia 1 Week Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Spinal Tumor Thoracic Spine Month physician and s the bunal-trans Due to (or as a consequence of): Physician/Medical Lymphoma Months attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease has been signed to the country of th 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate ha autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ▼ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760. within 24 hours after death

To the Funeral Director:
completely filled in by the

> State Registrar

Bruce Neckritz, NOV 15 2007

alle

29b. Signature end title of certifier

29c. License number H0059310

29d. Date signed (Month, Day, Year) Oct 29,2007

30. Name and address of person who completed cause of death (Italia 23a) (Type, Print)

14201 Laurel Park Dr #223, Laurel, MD 20707

D 92 Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Richard Allen Read October 29, 2007 9:30am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg 104 Dogwood Drive Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1X M 2 ☐ F 216-40-9969 64 Maryland Sept 10, 1943 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TrolYes 2 □ No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 104 Dogwood Drive 20877 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Yes 2 No Yes, Give Year or Dates: 1965 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☑ Divorced 1967 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Steam Fitting and Pipe Elementary/Secondary (0-12) College (1-4or 5+) 12 Boilermaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Boyd Richard Read Cora Golden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel F. Mullican 24300 Hipsley Mill Road, Gaithersburg, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 11/2/07 Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 21. Signature of Emperal Service Rart1. Enter the disease shock, or neart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown Ignificant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1∐ Yes 2 1 TYes 2 No 5 Residence 6 □Other (Specify)

**Physician** /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

I Hygiene.

permit. Pages 1 and 2 should be fife.
Department of Health and Mental Hy.
Important: If them Z7 is marked other
any injury or other trainer.

other

the Medical

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Directo

Funeral

δ

Completed

Be

Examine the as for use

physician and s the burial-trans After this certificate has e Hospital or Attending Pi 124 hours after death. e Funeral Director: After the letely filled in by the funeral

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Physician/Medical þ Completed 25. V Be

Medical

Certification: To

9	Unkn
Part II.	Other si

3 ☐ Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day, Year)

31

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

nanner of Death				26. Place of Dea	at
examiner? 1 X Yes 2 No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing F	lo
Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of		Injury at Work? 1 ☐ Yes 2 ☐ No	

(Month, Day Year) 6 ☐ Could not be determined

Work? М 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

1	(Check only one)	Medical Examine	or Or an	the basis of examination and/or investigation manner stated.	ation, in my opinion, death occurred at the tim	e, date and place, and due to the cause(s)
29b	. Conature an	d title of centifier			29c. License number	29d. Date signed (Month, Day, Year)

2007

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MODME

Registrar

32 degistrar's Signature

To the Hospital of within 24 hours at To the Funeral C

ride Tobias Riv	ers	State of Maryland / Department		ygiene	
		1- For State Certificate Registrar	of Death	Reg. No. 2007 36 (	5 7
Physicia Iedical Exami		1. Decedent's Name (First, Middle, Last) .  PRIJE TOLIAS RIVERS		2. Oate of Death Month Day Year October 20, 2007  3. Time of Death 1200 hrs	
		Frederick Memorial Hospital	4b. City, Town, or Location of Death Frederick	4c. County of Death Frederick	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	y) If Under 1 Year If Under 24Hrs	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	2.0
Director		161-48-0682 12M 20F 43	Yrs. Months Days Hours Min	07/15/1964 Foreign Pinshing	じ
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Lin	nits
<b>*</b>	ğ	MO. FREDERICK FRED		1 Yes 2	No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Director	1822 Way BRIDGE Po.	10f. Zip Code 2 170 2	10g. Citizen of What Country?  U. S. A	
th with tems 23 st be no	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		
ifter dea .l.", or it		1 Yes 2 No	Yes 2 No specify:	Specify: BLACK	
hours a "natura"	ted by	duri	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use ret	ired)	
036 ithin 72 ne. r than '	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  College 4	SERGEANT	MO. STATE POLICE	E
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical	Be Col	17. Father's Name (First, Middle, Last)  CLEVELAND RIVERS	18.Mother's Name	e (First, Middle, Maiden Surname) AIGE BUTLER	
212 hould be nd Ments is mark itic even	F B	19a. Informant's Name/Relationship (Type, Print)	lailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)	
and 2 sho lealth and tem 27 is traumati		20a. Method of Disposition 20b. Place of Di	isposition (Name of cemetery,	PAS FRED MA. 2(702 Date 20C. Location - City or Town, State	
More Pages 1 ent of F. unt: If i		1 Surial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:	or other place)  A JEN MEM. GARDENS	FRED MS.	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Significant of Funeral Service (censee	22. Name and Address of Facility	Ry L. ROLLINS FLUERALINOI ST. FRED. MO. 2,701	rë
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not er failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Inte	erval
/Medical xaminer		Immediate Cause (Final disease a Intraoral Gunshot Wound		Death	
- '		Sequentially list conditions, b			
	Examiner	if any, leading to immediate  Couse. Enter Underlying Couse (Disease or injury that initiated			
uted nd ransit	Exal	events resulting in death) Last  Due to (or as a consequence of):  d.			
be executed sician and urial - trans	dical	UNPENDED AMENDED			
68760 certificate b nding physise as the bu	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregn	23d. Date of delivery ancy Month Day Year	
× c a ii	Physician/Me	1 Yes 2 No 9 Unknown Pregnant at time of death 5	Other (Specify)		
P.O. Boy. sthat the deatigned by the attended for edetached for	by Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death	
ords, P.O w requires that is been signed be should be detail				24a. Was an 24b. Were autopsy findings avai	
Record The law re	Completed	<del></del>		autopsy prior to completion of cause death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No	
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	conly one)	
n of Vit ding Physic a. After this	ို	1 ✓ Yes 2 No Inpatient 2 ER/Outpater 27. Manner of Death 28a. Date of Injury 28b. Tim	atient 3 DOA Other Nursi	ing Home 5 Residence 6 Other:	
ion c tending eath. tor: Af the fun	ation	1 Natural 5 Pending Oct 20, 2007 Pending 2 Accident Investigation	rs 1 Yes 2 ✓ No	Subject shot self	
를 함 를 로	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm,	, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, or Town, State) South Bents and South Street , Frederick , MD	City
Hospi 24 hou Funer tely fil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause(s) and manner as stated.	
To the within 2 To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or inverse and manner stated.  29b. Signature and title ♠ certifier	stigation, in my opinion, death occurred  29c. License number	at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)	
	_	Pot Uso - Pollal	O.C.M.E.	October 21, 2007	
INH		30. Name and address of person who completed cause of death (Item 23a)	er 111 Penn Street Politime	ore MD 21201	
1041	tate	Patricia Aronica-Pollak MD. Assistant Medical Examina  31. Date filed (Month, Day, Year) 1 2007  32. Registrar's Signature		JIC, IVIU Z I ZU I	
Regis	4	31. Date filed (Month, Day, Year) 1 2007 32. Registrar's Signature	Sperle		

Registrar
OHMH 17 Rev 1/2001
OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rodriquez /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Easton Emorial Hospital at EASTON

ial Security Number 6. Sex, 7. Age (In yrs. last birth Talbot If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Days Min 582-05.8089 Sept. 28, 1928 Puerto Rico Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2 No or other traumatic event, the Medical Examiner must be notified Funeral Director 00+ Trappe 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö and ing 2/673 Neck Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: i 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married 1 ☑ Yes 2 ☐ No Specify: Hispanic Specify: Puerto Rican Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) armer Someone else's 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UnKnown Unknown ဥ 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5236 Landing Neck Road Trappe, Maryland 21673
ce of Disposition (Name of Date 200: Location - City of Town, State Bertha Rodriquez Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/07 Cambridge, Maryland Bethel 4 □ Donation 5 □ Other (Specify) CAMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. MD. 21613 510 washington St. Cambridge, 23a. Part. Enter the disease, or complications that cause whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia **Physician** hours /Medical Due to (or as a consequence of): Examiner Mana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a conse mence of) Examiner requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1☐ Yes 2☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 autopsy performe this certificate 2 **N**No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

Box 68760. Division or Vital Records,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) OCT 3 1 200

29b. Signature and title of certifier

Jennifer Hollywood, M.D., 219 S. Washington Street, Easton, MD 21601 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - State of Maryland		rtment of F			giene 007	36673
35	Physici	_	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year 9 2007	3. Time of Death 8:05A
	/Medic Examin	_	Jacob Ivin Scott  4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Deat		4c. County of Dea	
			Frostburg Village Nursing ( 5. Social Security Number   6. Sex   7. Age (In yrs. le	Care	Frostbu	rg I Under 24 Hrs	D. Data of Rid	Allegan	
1 82	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr.s. Iz 215-16-4170 13. The security Number 85		Months Days	Hours Min.	8. Date of Birt (Month, Date Nov 19	1921 Man	thplace (State or Foreign buntry) Yland
	ס	}	Usual Residence of Decedent						
	show	5		Town or Loc					10d. Inside City Limits 1 X Yes 2 □ No
	the N	rect	MD Allegany Fr	ostbu	10f. Zip Code			10g. Citizen of What Co	ountry?
	death with the Maryland rms 23e or 28e-f show	al D	206 Albert Avenue		21532		U	nited Sta	ates
	tems tems	uner	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of H Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	irs afte	by Funeral Director	1 Never Married 2 Married 1 TYPes, Give 194.	-	☐ Yes 21 No	Specify:		Specify: WH	ITE
5-0036	72 hou		15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ient's Usual Occup	pation during most of wo	rkına	16b. Kind of Business	/Industry
2121	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			during most of wo d)	4	Potomac E	dicon
d 2	filed v Hygie other t	င္ပ	10 17. Father's Name (First, Middle, Last)	Line	man	18. Mother's Na		Maiden Sumame)	GISOH
ılan	uld be Aental rked tic ev	To Be	William C. Scott			Martha	E. Blu	baugh Sco	tt
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. I nationate if it is marked other than "naturel; or items 23a or 28a-f show morprotent: If tem 27 is marked other than "naturel; or items 20a or 28a-f show eny injury or other treumatic event, the Modical Examinating must be inclined at once.	9	19a. Informant's Name/Relationship (Type, Print)					or, City or Town, State,	
e, <u>r</u>	1 and Health em 27 ther t		20a Method of Disposition 20b. Pt	ace of Dispos	sition (Name of	1	Date	rg, MD 21	
nor	ages ant of i nt: if it			matanı cran	natony or other ola	eark 11-		Frostburg	
Baltimore,	mit. P pertme porten y injur	1						4 60U Ms	in Street
8	Depe Impo Impo eny i		21. Signature of Funeral Service Licensee  ### ### ### ### ###################	S	owers i	unerai 2153	2 Home, P	Frost	purg, MD
				. Do not ente			c or respiratory ar	rest,	Approximate Interval Between Onset and Death
4:	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)  a	mee	~ 07	lung	_		6 montes
	Examiner			01100 017.		0			
A	Sit 9d	lner	Sequentially list conditions, a any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of).					
1/12	be executed icien end burial-transit	Examiner	resulting in death) Last  C. Due to (or as a consequ	ence of):					
	ate be ex nysicien he buria	calE	d.						
89	intificating physics as the	Medi	IF FEMALE:						
Вох	death certificate e attending phys d for use as the	lan/I	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnant 1 Live birth 2 Fetal	death 3	Ectopic pregnanc	у		23d. Date of de Month	livery Day Year
P.O.	that the de ed by the a detached	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	am 5	Other (specify)				The state of the s
	requires that the een signed by th rould be detache		Part II. Other significant conditions contributing to death but not resu	Iting in the un	nderlying cause giv	ven in Part I.		obacco use contribute t	o the cause of death?
ord	w require been si should b	ted	Severe Obstruct	700	rung	ous?	اللا عدد	/es 2□No 3□P	robably 4 ∏Unknown
3ec	has has	Completed by	CHT				24a. Was autop perio	an 24b. Were a prior to death?	utopsy lindings available completion of cause of
tal		င္ပ	25. Was case referred to medical			26 Place of De	1 ☐ Yes	2 No 1 Yes	s 2□ No
Ž	d is	To B	examiner?  1  Yes No Hospital: 1 Inpatient 2 E	ER/Outpatient	t 3 DOA Ott	ner: 4 Nursing I	Home 5 Resid	dence 6 Other (Spe	əcify)
o no			1 Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injui Wo M 1	nyat rk? ∣Yes 2 □ No	28d. Describe	now injury occurred	
Division of Vital Records,	Attending r death. ector: Afte by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	me, farm, str		1195 2 1140		Street and Number or R	ural Route Number,
Ó	s after si Dire	Certification;	4 ☐ Homicide determined building, etc. (Specify,	)			City or Tov	vn, State)	
	To the Hospitel or Attent within 24 hours after death To the Funersi Director: completely filled in by the	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination)	illedge, death ion and/or inv	restigation, in my o	me data and place opinion, death occ	e, and due to the urred at the time,	rausa(s) and manner a date and place, and du	s stated e to the cause(s)
	o the ithin 2 o the omplei	Med	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
	rs⊢ö		> 5 C Soundle	w	D	1446	4	NOV 9.	2007
_	1.		30. Name and address of person who completed cause of death Tham				4.		
	V Cr		S. I. Sandhir, MD 48 Tarn T 31 Date filed (Month, Day, Year) 32. Segistrar's Signat	errac	e Frost	burg, J	MD 2153	2	
	Sta Registr		NOV 1 5 2007	S. Page	34.20				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nellie Virginia Stotler 6:45 a.m. November 8, 2007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death NMS Healthcare of Hagerstown Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 236-50-0823 1 M 2 XX 90 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Morgan Great Cacapon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25422 U.S.A. 461 Wiggins Run Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ma If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify: Specify: White XX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dayton V. Kidwell Grace Peck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger L. Brown P.O. Box 104, Great Cacapon, WV 25422 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State Warial 2 ☐ Cremation 3 ☐ Removal from State Great Cacapon Cemetery 11/10/07 Great Cacapon, WV 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee Heisley-Johnson Funeral Home, Inc. M00522 95 Union St., Berkeley Springs, WV 25411-1855 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Scasz DYONAY Due to (or as a consequence of) ard, o myo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XXXo Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed 2 No 1∐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

WV

Director

Funeral

by

Completed

Be

ပ

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than "ne any injury or other traumatic event "to once."

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Division or Vital Records, P.O. Box 68760, nse for ed by the a detached f signed I I be det page 2 s certificate director this funeral After death. 24 hours after death Pruneral Director: filled in by the

Examiner Physician/Medical Be Completed by

Certification: To Medical

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□ N**o 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

BNID

29b. Signature and title of certifier

NOV 15 2007



and manner stated.

106039C

29d. Date signed (Month, Day, Year)

Registrar

completely

within 2.

Hospital

			For 1 - State Registrar	State of Man		artment o		ınd Men	ntal Hygien	.2007	36675
			Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
	Physici /Medic		Anita Grace Sow	ers				N		11, 2007	
	Examin		4a. Facility Name (If not institution, give st	reet and number)		*	n, or Location of	f Death		c. County of Deal	h
			1942 Sidnee Drive  5. Social Security Number 6. Sex	7. Age //	In yrs. last birthday)	Edgev		24 Hrs.   8	Date of Birth	Harford 9. Birt	hplace (State or Foreign
	Funeral Director			м 2Ё¥ 73	Yrs.	Months Da	ys Hours	Min. 1	07307193	4 Mar	yland
	D *		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town or Lo	cation					10d. Inside City Limits
	Maryla 1 • ho	2	Maryland Harford			ewood					Yes 2 No
	r 28a-	Director	10e. Street and Number			10f. Zip Cod	ie		10g. (	Citizen of What Co	puntry?
	within 72 hours after death with the Maryland ene. Than "natural" or items 23a or 28a-f ehow Ta Medical Examinar must ba notified at	al D	1942 Sidnee Drive	e		21	1040		U	.S.A.	
	er dea	Funeral		2. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent f Yes, specify (	of Hispanic Orig Cuban, Mexican,	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Race - Ame Black, Whit	
35	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🗗 No If Yes, Give Year or Dates:		1□Yes 2█	No Specify:			Specify: W	hite
9500-612	72 hou	ted	15. Decedent's Educa		16a. Dece	dent's Usual Oc	ccupation one during most	of working	16b.	Kind of Business	Industry
2	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use re	atired)	OF WORKING	_		
N.	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Homen	naker	18 Mother	r's Name /Fi	rst, Middle, Maid	n home	
⊑	d be f	o Be	James Franklin Wh	itcomb				rrie W		or comano,	
Mary	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. I file m 21 to marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at	۲	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Str	reet and Number	r or Rural Ro	oute Number, City	or Town, State,	Zip Code)
	end 2 ealth m 27 I		Donald Sowers, Sr			Sidne		0.00	ewood, M		
or e	8 = 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State		natory`or other	place)	Date  1/15/		Location - City or t Cheste	
baltimore,	nit. Pages vartment of cortant: If It Injury or o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Pensee	1	R. A. Fer		ddress of Facility		o, wes	t Gleste	I, FA
ğ	Dep in a constant of the const		1/1/Aen/ne	WMAL II	MU I	arring- berdeer	-Cargo É	unera	1 Home 21001-33	99 <sup>A</sup> .	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only only	ations that caused the cause on each line.	e death. Do not ent	er the mode of	dying, such as o	cardiac or re	spiratory arrest,		Approximate Interval Between
. [	Physician	,	Immediate Cause (Final disease or condition	Me	etastati	c (li	my Ca				Inset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	consequence of):		$\bigcirc$				)
	16.	e	S ve uentially list conditions, it any, leading to immediate	Due to (or as a c	onsequence of):				-=		
3.	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c.								
, 60,	ate be executed hysician and he burial-transit	i Ex	resulting in death) Last	Due to (or as a c	onsequence of):						
-	ficate physics the t	edicai	d.								
XOR	leath certificat attending phy I for use as th	In/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of 1 Live birth 2		∃Ectopic pregna	2004			23d. Date of de	
	e death he atten sed for u	Physician/Med	in the past 12 menths? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tirr 9☐Unknown		Other (specify				Month	Day Year
7. O	hat the de od by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions cont		not resulting in the u	nderlving cause	e given in Part I.		23e. Did tobacc	o use contribute to	the cause of death?
ds,	requires that leen signed b hould be deta	d by				, ,			1 Yes	2 □ No 3 □ P	robably 4 Unknown
ecor		Completed							24a. Was an	24b. Were a	utopsy findings available completion of cause of
r	The ate h page	Com							autopsy performed* 1 ☐ Yes 2 ☑	death?	2 No
VITA	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			Othor		heck only one)		
ō	<u>o</u> = e	. To	1 Yes 2 No	1 🔲 inpatient	2 ER/Outpatier				5 Residence  Describe how in	6 ☐Other (Spe	icify)
0	Attending Phy r death. ector: After thi by the funeral	ation	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	'ear) Injury		Injury at Work? 1 ☐ Yes 2 ☐ N				
		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str (Specify)	eet, factory, off	fice	28f.	Location (Street City or Town, St		ural Route Number,
٦ ,	e Hoepital or 24 hours afte Funeral Dis etely filled in		20a Cartifier 17 Cartifying Physic	ping. To the heat of a	mu kanuladan dasi	h	antima data ana	d place and	due to the serve	(a) and minner a	a stated
	• Hospital 24 hours a • Funeral letely filled	Medical	29a. Certifier 1 Certifying Physic (Check only one)	er: On the basis of ex and manner stated	camination and/or in	n occurred at the vestigation, in the	ne time, date and my opinion, deat	d place, and th occurred a	at the time, date a	ind place, and du	s stated. a to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	, .		1 _	cense number		29d. I	Date signed (Mon	th, Day, Year)
		18	· Da			1	548	541		11/12	10+
	2	V	30. Name and address of person who cor PSh Kan Buhran	i, mis. L	1025 At	Wyad 1	Rd. B	00 UAir	, MD.	21014	
	Sta Registi	-	31. Date filed (Month, Day, Year) 2007	32 Registrar's	s Signature	ALS.					

7-08599 lyles Orion Solowe	vey	Please Type or Print in Black Indelib State of Maryland / Departmer	ole Ink. Ensure and	<b>All Copies Are Leg</b> Mental Hygiene	jible.
Physician/	1- <u>Re</u>		te of Death	Re 2. Date of Death	
Medical Examine	er	Myles Orion Solowey	1	Month November	Day Year 5, 2007 0735 hrs
ŧ .	48	Facility Name (if not institution, give street and number) 823 Cove Point Road	4b. City, Town, or Lo	cation of Death	Calvert
Funeral Director	L	Social Security Number $130-69-5434                                   $	day) If Under 1 Year Months Days	If Under 24Hrs. 8. Date of Birth Hours Min. 07/27	h(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) TN
Land f show any once.	11	ia. State 10b. County 10c. City, Town or MS Pike McComb	)		10d. Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f sh lifted at once	Direct	ne. Street and Number 1128 Berthadale Road	10f. Zip Code 39648		United States
er death with 1 , or items 23 r must be not	Funeral	I. Marital Status  Never Married  2 X Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 X No  Widowed  4 Divorced If Yes, Give Year  or Paleir		anic Origin? ( Specify Yes or No- Mexican, Puerto Rican, etc.) specify:	14. Race - American Indian, Black, White, etc.  Specify: White
hours a	ed by	du	ecedent's Usual Occupatio uring most of working life. [		16b. Kind of Business/Industry
D36 thin 72 ne. than " ledical	Completed		on Worker		Industrial Construct
15-0036 filed within 77 l Hygiene. ed other than t, the Medical		7. Father's Name (First, Middle, Last) Thomas E. Solowey	18	B.Mother's Name (First, Middle, I Frances Y. Har	
D 2121: should be fill and Mental It 7 is marked affic event,		9a. Informant's Name/Relationship (Type, Print ) 19b.			nber, City or Town, State, Zip Code)
e, MD I and 2 sho Health and item 27 is	2	Da. Method of Disposition 20b. Place of	f Disposition (Name of cem-		20c. Location - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite Important: If ite Important or other tr	ı	X Bunal 2 Cremation 3 Removal non-state	ce Family Ce		McComb, Mississippi
Balti permit. Departir Import injury	2	1. Signature of Funeral Service Licensee	22. Name and Address	<sup>of Facility</sup> Rausch I 600, Lusby, <u>M</u> ai	Funeral Home, P.A.
Physician /Medical xaminer		3a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.  mmediate Cause (Final disease or condition resulting in death)  a. Methadone intoxication of the condition of the condition resulting in death)	t enter the mode of dying, s	such as cardiac or respiratory an	rest, shock, or heart Approximate Interval Between Onset and Death
	miner	Sequentially list conditions, and the family leading to immediate ause. Enter Underlying Cause Disease or injury that initiated			
		vents resulting in death) Last Due to (or as a consequence of):			517
0 10	dical	XUNPENDED AMENDED 27,28a-f, per	Æ,g874, 12/11/0	07_TT	
Box 68760, e death certificate be ex the attending physician ed for use as the burial	cian/I	TEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnancy	23d. Date of delivery  Month Day Year
ires that the de signed by the dedetached f		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause g		tobacco use contribute to the cause of death?
cords law requested that the seconds is a should be seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the seconds in the second in the sec	Completed by			24a. Was auto perf	s an 24b. Were autopsy findings available
of Vital Recing Physician: The After this certificate uneral director, page	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Ou		of Death (Check only one) Other  Nursing Home 5	Residence 6 V Other: Scene
Ing Phys	1,1	1 Yes 2 No			e how injury occurred
ion (trendin leath. Ator: A	atior	Natural 5 Pending Fnd 11/5/2007 FNd	1 / <u>:20 am  </u>	es 2 X No unk	(O) I AN I I I I I I I I I I I I I I I I I
Divisation A rat Direct rat Direct Di	Certification:	3 Suicide 6 X Could not be determined (Specify) House	arm, street, factory, office b	or Town,	(Street and Number or Rural Route Number, City State) ve Point Rd. Lusby, M
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filted in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea cone) 2 Medical Examiner:On the basis of examination and/or in	ath occurred at the time, da investigation, in my opinion	ate and place, and due to the cau, death occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
To To com	Mec	29b. Signature and title of certifier	29c. Licens		29d. Date signed (Month, Day, Year)
		30. Name and softress of person who completed cause of death (Item 23a)	0.C.I		November 6, 2007
Ø		Pamela E. Southall, MD Assistant Medical Examine  31. Date filed (Month, Day, Year)  32. Registrar's Signature	er 111 Penn Street	t, Baltimore, MD 21201	
Sta Registr	1	MOV 1 5 2007	for the		2010
DHMH 17 Rev 1/200 OCME 2006	001	OR	USINAL		OCME

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Shari Kettii Sta		1- For State Registrar		i iviaryianu /		tificate of D		iu ivierita	Re	201 g. No.	
Physic Medical Exam		Decedent's Name		ערדייט	CT! A	IIINCC			2. Date of Deat Month November		3. Time of Death 1644 hrs
20		4a. Facility Name (if	BRIAN not institution, give	KEITH street and number)	51A	LLINGS 4b.	City, Town, o	or Location of D		4c. County of Deat	
		4806 Sherida					Riverdale	The second		Prince Georg	
Funera Director		5. Social Security No. 579-76-18 Usual Residence of	383 1X	7. Age	(In yrs. Ia:		If Under 1 Ye Months Da		Min.	th(MM/DD/YYYY) 9. Bi Forei 19,1957	
any			10b. County		10c. City,	Town or Location					10d. Inside City Limits
land Fshow pre.	Į.	MD.	PRINCE GE	EORGES		RIVE	RDALE				1 X Yes 2 No
r 28a-l	Director	10e. Street and Num	nber			1	0f. Zip Code		11	og. Citizen of What Co	untry?
ROLT eath with the items 23a o	al D	4806 S	SHERIDAN S	ST • 12. Was Decedent I	-ver in I1.9	S 13 Was I		20737	? ( Specify Yes or No	U.S.A.	rican Indian, Black,
leath w	Funeral	Never Marrie		Armed Forces?	₹ No				uerto Rican, etc.)	White, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
after c	by F	3 Widowed	4 X Divorced	f Yes, Give Year or Dates:			es 2 X N				HITE
hours; hours	ted	15. Decedent's Edit	ucation (Specify only	y highest grade com College (1-4 or 5		16a. Decedent's during most		ation (Give kin fe. DO NOT us		16b. Kind of Business	,
336 thin 72 re. than	Completed	12	ildaly (0-12)	College (1-4 of 5	')	AN	гтоне :	RESTORE	R	GABRIEL A	ND STALLINGS RESTORATION
21215-0036 suld be filed within 7 Mental Hygiene. marked other than re event, the Medica	So	17. Father's Name (	First, Middle, Last)						Name (First, Middle, I	Maiden Surname)	REDICITATION
121 Id be fil Aental	Be	19a. Informant's Nar	DAVID	EUGENE	STA	LLINGS	ddross (St			ARROLL STA	ALLINGS
MD 2 nd 2 shou lith and M m 27 is n aumatic	٩	BRANDEN	STALLING			,	,			E, MD. 207	
re, R 1 and 1 Health Fitem er trau		20a. Method of Disp	osition			Place of Disposition	on (Name of		Date	20c. Location - City of	
Pages	2		Cremation 3 Other Specify:	Removal from Sta	10	MBERS CI	REMATO		1-8-2007	RIVERDAL	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 275 marked other than "natural", or items 23a or 28a-f show any Iningry or other tranumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	Chan	Much	7 M00	1071 J81	OL CLE	VELAND	AVE., RIV	CREMATORIUM ERDALE, MD	M,P.A. .20737
Physiciar /Medica			e disease, or compli y one cause on eac		the death.	Do not enter the	mode of dyin	ig, such as card	liac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
camine		Immediate Cause (F or condition resultin		Cocaine into							Death
		Sequentially list con	- L	de to (or as a conse	quence of	<i>)</i> .					
	iner	if any, leading to im cause. Enter Under	mediate D rlying Cause	ue to (or as a conse	quence of	7):					
xecuted n and - transit	Examiner	(Disease or injury the events resulting in contact the events resulting in events		oue to (or as a conse	quence of	·):	-				
be exec	Medical	X UNPENDED		#ENDED #23a,27,28	a-f. p	erME.g873.	11/16/	07 тт		-	
3760, ficate be exe g physician a	_	IF FEMALE: 23b. Was decedent;	pregnant in the	23c. If yes, outcom		nancy	death	3 Ectopic p	reanancy	23d. Date of delive Month	ery Day Year
Box 687 e death certific the attending F	sician/	past 12 months		4 Pregnant at	time of de	oth -	r (Specify)			Nontri	Day Foo.
. Bo the dea y the a	Phys	1 Yes 2 N		g Unknown contributing to death	but not re	eulting in the un	terlying caus	e given in Part	I 23e Did t	obacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68: ral or Attending Physician: The law requires that the death certifinate death.  The all Director. After this certificate has been signed by the attending led in by the fineral director, near 3, should be detached for use as it.	ed by			contributing to deat	T Dat Hot re	southing in the unit	Terrying caus	e given in rait	1Ye	s 2 No 3 Pr	obably 4 🗸 Unknown
ords aw requas beer	Completed								24a. Was		autopsy findings available completion of cause of
tal Rec	5								1 ✓ Yes		
ion of Vital   tending Physician: eath, for: After this certif the fineral director.	Be	25. Was case referr examiner?	Н	ospital: 1 Inpatie	nt 2	ER/Outpatient		Other	heck only one) Nursing Home 5	Residence 6 ✔ Oth	ner: Scene
of Vi ing Physi After this	1: To	1 ✓ Yes 27. Manner of Deatl	h No	28a. Date of Inju (Month, Day,Y	ry	28b. Time of Inju	<del></del>	njury at Work?		how injury occurred	100000
ion itendin leath tor: A	atio	1 Natural 2 Accident	5 Pending Investigatio	End 11/3		Fnd 4:40	pm 1	Yes 2 X N	unk unk		
Divisior Hospital or Attend 24 hours after death Funeral Director: Felv filled in by the	≒=	3 Suicide 4 Homicide	6 X Could not b	e 28e. Place of In		ome farm, street, n residenc	•	e building, etc.	or Town,		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and counciled filled in whe finned after the 2 should be detached for use as the bural - transi	Medical C	29a. Certifier	Medical Examiner:	n: To the best of m	y knowled	ge, death occurre	d at the time.		e, and due to the cau	se(s) and manner as si and place, and due to	ated.
To with	Mec	29b. Signature and		and manner stated.			29c. Lice	ense number		29d. Date signed (A	Month, Day, Year)
		Ca	e de 4	fall	elv		0.0	C.M.E.		November 4, 2	007
			ess of person who c	ompleted cause of d		23a) 111 Penn St	reet Ralti	more MD 3	21201		
	State	Carol Allan, 31. Date filed (Mo	is other a March	22 Periotro		ле		more, ND 2	. 1401		
Regi			40 8 0 9 20	107 32. Registra	u.	U. Ka	elle I				

State Registrar

OCT 3 0 2007

30. Name and address of p

Straut =

22. Registrar's Signature

Stewn & Spark

son who completed cause of death (Item 23a) (Type, Print)

onicu, mo

e(

Bestrate Annapolis,

3H-5

State Registrar 31. Date filed (Month, Day, Year) 8 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

on all

MILL STUAKERSTOWN MD 21740

State Registrar TLAYCEN A
31. Date filed (Month, Day, Year)

BOCARUMIND. 196 TJ DRIVE, FREDEUCK, MD-21403

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

NOV 0

32. Registra 's Signature

Eleve

		_	For State Registrar	State of Maryland	•		t of Health and Me of Death	R	Neg. No.2 0 0 7	36681
B	Physicia		1. Decedent's Name (First, Middle, L John Joseph Shor					2. Date of Dea Month October	28, 200 <sup>Yea</sup>	3. Time of Death 5:30 PM
	/Medic Examin		4a. Facility Name (If not institution, g 12922 A Hessong				Town, or Location of Death		4c. County of De	eath .
	Funeral Director		5. Social Security Number 6. 219-12-0310  Usual Residence of Decedent	Sex 7. Age (In yrs. la 1 ☑ M 2 ☐ F 82	st birthday) 2 Yrs.	If Under Months		8. Date of Birth (Month, Day April 14	, Year) 9. E 4, 1925 M	Birthplace (State or Foreign Country) aryland
	the Maryland 28a-f show	ector	10a. State 10b. County  Maryland Freder:  10e. Street and Number		Town or Lo		Codo	1.	10g. Citizen of What	10d. Inside City Limits 1 Yes 2 No
	h with 23a or	al Dir	12922 A Hessong	Bridge Road		TOI. Zip	21788		United S	
036	should be filed within 72 hours after death with the Maryland di Mental Hygiene. marked other than "natural, or items 23a or 28a-f show marked other than "natural, or items 23a or 28a-f show marked other than "natural tenutified at martine went, the Macical Examinar maint be nutified at	by Funeral Directo	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 155Yes 2 □ No If Yes, Give Year or Dates: WWII			ent of Hispanic Origin? (Spirfy Cuban, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Al Black, W Specify: W	
Maryland 21215-0036	within 72 ho ene. than "natur ne Medical I	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education trade completed)  College (1-4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	Il Occupation rk done during most of work e retired)	king	16b. Kind of Busine Transport	
פ	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle, La	st)	Truc	K DI		ne (First, Middle,	Maiden Sumame)	
<u>S</u>	ould by Menta	To E	Frank Shorb				Elizabet		<del></del>	
Z Z	nd 2 sh Ith and 27 is rr r treurr		19a. Informant's Name/Relationship Helen Shorb / Wi				Street and Number or Russong Bridge			
Baltimore,	permit. Pages 1 and 2 should be Depertment of Heath and Menta Important: If tem 27 is marked eny injury or other treumatic et ance.		20a. Method of Disposition  1 ── Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Control of the Contro	□Removal from State 20b. Pla		sition (Name	ne of the place) Nov.	Date 1,	20c. Location - City	
Balt	permit. Depertmine imports eny inju		21. Signature of Furural Sarvice Un	ensee			d Address of Facility 1 State of Funeral State of Funeral State of Facility 2	Services	, Skkot Co	ody P.A.
			23a. Part1. Enfer the disease, or co shock or heart failure. List on Immediate Cause (Final	mplications that caused the death, by one cause on each line.	. Do not en	ter the mod	e of dying, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	a. GASTNIC CA Due to (or as a consequent	ence of):					
	ř	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. CORONARY  Due to (or as a cons	ence of):	TERU	DISEASE			
oʻ	e be executed /sicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. CHOONIC  Due to (or as a consequence)	0/357 ence of):	nno T	7VE Puin	news	DISSA!	3_
68760,	7 7 9	dlcal		d. HOWERTEN	SIC	~~				- N
.O. Box 6	Attending Physician: The law requires that the death certificate be ex redeath.  ector: Atter this certificate has been signed by the ettending physicien better this certificate as the burian by the tuneral director, page 2 should be deliached for use as the burian	Physician/Med	#FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 \( \subseteq \text{Live birth} \) 2 \( \subseteq \text{Fetel} \) 4 \( \subseteq \text{Pregnant at time of de} \) 9 \( \subseteq \text{Unknown} \)	death 3[	⊒Ectopic pr ⊒ Other (sp			23d. Date of Month	delivery Day Year
Δ.	quires that n signed by uld be deta	þ	Part II, Other significant conditions		lting in the u	inderlying c	ause given in Part I.	23e. Did to	/	e to the cause of death? Probably 4 □Unknown
l Records,	Physician: The law requir this certificete has been si ral director, page 2 should	Completed	LOW RACK	PATIN	51				rmed? prior death	autopsy findings available to completion of cause of 1?
Vital	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor	ath (Check only o	· · · · · · · · · · · · · · · · · · ·	
Division of	ding Phys th. After this funeral di	tlon: To	1 ☐ Yes 2 ☐ No  27. Manney of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigal	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		A Nursing H 28c. Injury at Work? 1 ☐ Yes 2 ☐ No		dence 6 Other (S	Specify)
Divisi	i i i i i	Certification:	3 Suicide 6 Could no determine	t be 300 Blace of Injury At hou	me, farm, st	reet, factor	y, office	28f. Location (S City or Tox		r Rural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examinati and manner stated.	wledge, dea ion and/or ir	th occurred nvestigation	at the time, date and place, in my opinion, death occu	a, and due to the ourred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the	Σ	29b. Signature and title of certifier	110			c. License number		29d. Date signed (M	
	×		30. Name a ddress of person w	no completed cause of death (Item	23a) (Type	Print)	MD02563	368	UCT3-382	3/ 2007
\	9		Dressett 120 ch 17	AC MS 52	4 5.	WAS	HINGTON S	T GE	77458	1 94 1752
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ture	board				

		For	Pleas	e Type or Pri State of M		d / Dep	artment of H	lealth	and M			gible.	
		- State Registrar				Ce	rtificate of	Death	7		Reg. No.	007	2000
Physicia		Decedent's Name		Last)						<ol><li>Date of De Month</li></ol>	Day	U U 7	3. Jmporpeati Z
/Medica		WILLIA	M R	S	TROH					OCTOBE	R 30,	2007	8:00 P M
Examine	r			give street and number)			4b. City, Town, o					inty of Death	
				RIAL HOSPIT				DERI(				REDERI	
Funeral		5. Social Security N		5. Sex 7. Ag	ge ( <i>in yr</i> s 87	last birthday, Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Coui	
Director	-	202-09-5 Usual Residence of			07			<u> </u>		Nov. 1	2, 191	9 Penn	sylvania
yland now at		10a. State	10b. County		10c. City	y, Town or L	ocation						Od. Inside City Limits
Mar a-f sh ified	10	Maryland	Freder	ick	M	ount A	iry						X□Yes 2□No
or 28	Director	10e. Street and Nur	mber				10f. Zip Code				10g. Citizen	of What Cou	ntry?
23a ust b		1706 S	South Ma	in Street			21771	L			U	.S.A.	
ours after death with the Marylar ral", or Items 23a or 28a-f show Examiner must be notified at	Funeral	11. Marital Status		12. Was Decedent Armed Forces	?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic O an, Mexica	rigin? (Spean, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White,	
s afte	by F	1 ☐ Never Marri 3 ☐ Widowed		d 1 ☐ Yes 2 X☐ If Yes, Give Year or Dates:	No		1 □ Yes 2 □ No	Specify	y:		Spe	ecify: W	hite
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at		3 - Widowed	15. Decedent's			16a Dece	dent's Usual Occup	nation	-	-	16h Kind d	of Business/In	
in 72 n "na Nedic	olet.		cify only highest	grade completed)	- \	1 (Give	kind of work done DO NOT use retired	durina ma	st of work	ing			333)
with giene r tha the A	Completed	Elementary/Seco	ondary (U-12)	College (1-4or	5+)	Ar	chitect				Bui	lding	
othe /ent,	Be	17. Father's Name	(First, Middle, L	ast)		'		18. Moth	her's Name	e (First, Middle	Maiden Sur	name)	
Aenta Aenta rked tic ev	0	Samue	1 Lowr	y Stroh				He	len	Rockef	eller		
2 should be and Mental is marked craumatic even		19a. Informant's Na	ame/Relationshi	p (Type. Print)		19b. Maili	ng Address (Street	and Numi	ber or Run	al Route Numb	er, City or To	wn, State, Zip	Code) 21771
and 2 ealth n 27 i		M. Bett	y Stroh	- Wife			6 South M	lain	Stree	et, Mo	ınt Ai	ry, Ma	ryland
of He		20a. Method of Disp		3 □Removal from State	.   0	cemetery, cre	osition (Name of matory or other plac			Date		on - City or T	own, State
Pages ment of H ant: If ite			5 Other (Spe		P:	ine Gr	ove Cemet	ery	Nov.	3, 20	07 Mo	unt Ai	ry, Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagnee.		21. Signature of Fu	underal Service L	censee Willi	in	~	<sup>2. Name and Addre</sup> Moleswort 26401 Rid	h-Wi	11iam	ns P.A.	Fune:	ral Ho	me d. 20872
Physician		shock, or hea Immediate Cause ( disease or conditio	ırt failure. List o (Final	complications that cause nly one cause on each	d the death ine.			ng, such a	as cardiac			aryran	Approximate Interval Between Onset and Death
Medical Examiner sician and burial-transit	al Examiner	resulting in death)  Sequentially list co if any, reading to int cause. Enter Unde Cause (Disease or that initiated events resulting in death) I	5	b. Due to (or as Due to (or as	AOC s a conseq O C CO	ardi	tis tic a	ort	16	Valu	C		
The law requires that the death certificate be the has been signed by the attending physicia oage 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	23c. If yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Feta	al death 3	_Ectopic pregnanc ☐ Other <i>(specify)</i> _	у				Date of deliv Month	Day Year
w requires that been signed I should be det	2	Part II. Other signif	ficant condition	ns contributing to death I	but not res	ulting in the t	underlying cause giv	ven in Part	t I.		obacco use o Yes 2 □ N		he cause of death? bably 4 X Unknown
	Completed									24a. Was auto perfo 1∏ Yes	psy ormed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
sician: The certificate rector, pag	Be	25. Was case refer examiner?	rred to medical						ce of Deat	h (Check only	one)		
Physi this o	0	1  Yes 2 X		Hospital: 1 Inpat		ER/Outpatie		4 🗆 ۲		me 5 Resi			fy)
Ing F After Uner	Ö	<ol> <li>Manner of Deat</li> <li>Natural</li> </ol>	5 Pending		ury ay Year)	28b. Time of Injury	Wor			28d. Describe	how injury or	ccurred	
or Attencather death	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	investiga 6	ot be 28e. Place of in	jury - At ho tc. (Specif		M 1 □	Yes 2		28f. Location ( City or To	Street and N wn, State)	umber or Rur	al Route Number,
	Medical Co	29a. Certifier (Check only one)		Physician: To the bes examiner: On the basis and manner s	of examina								
To the within to the complex c	Ĭ	29b. Signature and	title of certifier	+ Nag	F		29c. Licens					gned (Month,	Day, Year) 1, 2007
10	1	30. Name and addr	ress of person w	ho completed cause of	death (Iten	n 23a) (Type	, Print)						
10		Aubrie	e J. Nag	gy M.D. 3	00 We	st 9tl	Street,	Fred	leric	k. Marv	1and	21701	
Stat	-	31. Date filed (Mon		2 2007 32. Regist	r's Signa	ature							
Registra	ır		- 100	2 2007 32. Regis	low	K	Sparle						

					Type or Pr						•		egible.	
			1_ For Ame	end #31 r	State of Notice	Maryland 10-31-	d / Depa -2007	artmer CNM	t of H	ealth and N	Mental Hy	giene	007	06600
			Registrar  1. Decedent's Name (i				Cei	runca	e or L	Jeain	2. Date of De		UU /	35553 3. Time of Death
	Physicia		MARILYN	L.	STIMPFI	Œ					Month OCTOBEF	Day	Year 2007	6:35A M
	/Medic Examin		4a. Facility Name (If no					4b. City	Town, or	Location of Death		1	unty of Dea	
200		A.	FREDERICK N						DERIC		T		DERIC	
	Funeral Director		5. Social Security Num 288-24-561	1	ex	Age (In yrs. I 79	ast birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	Co	thplace (State or Foreign ountry)
			Usual Residence of De	Decedent							Sept.1	1,1920	<u>'</u>	Ohio
nelvien nelvien	show	J.		10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	28a-f notifie	Directo	Maryland   10e. Street and Numb	Freder	rick	Fre	ederic		p Code			10g Citizer	of What Co	
him	3a or st be		7407 Willo		Apt. 453					702			ted S	
- deap	ems 2	Funeral	11. Marital Status	Witoera	12. Was Deceder Armed Forces	nt Ever in U.	S. 13.	Was Dece		spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No			erican Indian,
o affe	, or it	by Fu	1 ☐ Never Married 3 ☑ Widowed 4		1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	₹ No		1 ☐ Yes		Specify:	, , ,	1 _	pecify:	
22 hours after death with the Manuard	tal Hygiene.  dother than "natural", or items 23a or 28a-f should the Medical Examiner must be notified at event, the Medical Examiner must be notified at		1:	15. Decedent's Ed	lucation	·.	16a. Dece	dent's Usi	al Occup	ation		16b. Kind	of Business	nite /Industry
<b>6</b> 10 2	- 4	Completed	(Specify Elementary/Second	dary (0-12)	de completed)  College (1-4o	r 5+)	(Give life.	kind of w DO NOT i	ork done d ise retired	during most of worl )	king			
filed within	her th		17. Father's Name (Fi	inst Atiddle Leat	4		]	Homen	aker	18. Mother's Nam	o /Eirot Middlo		m Home	e
D be	ental F	o Be	Clifford D								•	, Maluell Su	mame)	
should be	md Me	2	19a. Informant's Nam				19b. Mailir	ng Addres		Lucille l and Number or Ru		er, City or T	own, State,	Zip Code)
and 2	n 27		Julie Par	:laman/ I	Daughter					e Pike, 1				
Page 1	it of H		20a. Method of Dispos 1 ☐ Burial 2 🔀		Removal from Sta		lace of Dispo emetery, crea	osition (Na matory or	me of other plac	e)	Date	20c. Loca	tion - City or	Town, State
<u>a</u>	; <b>‡</b> ₽ ₽ ;		4 □ Donation 5  21. Signature of Earner	5 ☐ Other (Specification Service Licen		Sta				y, INC 10			rick,	Maryland
ם פ	Depar Impor any ir		101	del E	1 Wen	M				ss of Facility uneral Ho			k. Ma	ryland 21702
H			23a. Part 1. Enter the shock, or heart	e disease, or com	plications that caus one cause on each	ed the death							104	Approximate Interval Between
	hysician		Immediate Cause (Findisease or condition resulting in death)	inal	a. lunc	a in	filtr	ates	>					Onset and Death Day S.
	/Medical xaminer		resulting in death)		Due to (o	s a consequ	uence of):							0
v	. de	Jer	Sequentially list cond if any, leading to imm cause. Enter Underly	ditions, nediate	b Due to (or a	as a consequ	uence of):							
John John	und transil	Examiner	Cause (Disease or inj that initiated events resulting in death) Las	njury	c									
The law requires that the death certificate he even that	attending physician and for use as the burial-transit		resulting in death, East		Due to (or a	as a consequ	uence ot):							
in or or or or or or or or or or or or or	g phys	sician/Medical			d									
5	endine r use a	M/us	IF FEMALE: 23b. Was decedent p		23c. If yes, outcor			⊒Ectopic i	regnancy			230	d. Date of de	
	the att	/sici	in the past 12 m 1 ☐ Yes 2 ☐ I 9 ☐ Unknown		4□Pregn <i>a</i> nt 9□Unknowr	at time of d		Other (s					Month	Day Ye <i>a</i> r
that #	been signed by the should be detached	/ Phys	Part II. Other signific	cant conditions	contributing to death	but not resu	ulting in the u	ınderlying	cause giv	en in Part I.	23e. Did	tobacco use	contribute t	o the cause of death?
	n sign	sd by									1 🗆	Yes 2□	No 3□F	Probably 4 Unknown
ב ב	as bee	Completed									24a. Was		24b. Were a	utopsy findings available completion of cause of
	cate h	Com									perf 1□ Yes	ormed? 2 No	death? 1 ☐ Ye	_
V II.C	certifi	Be	25. Was case referred examiner? 1 ☐ Yes 2 ▼ No.	,	Hospital:				OA Oth	26. Place of Dea				
5 4	or death.  rector: After this certificate has by the funeral director, page 2.	: To	27. Manner of Death		28a. Date of I	njury	28b. Time of		28c. Injur Wor	4 Li Nursing n	ome 5 ☐ Res 28d. Describe			ecify)
	ath.	ation	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	n	Day Year)	Injury	М		Yes 2 □ No				
NIVIS OF ATT	fter de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	Zoe. Place of	injury - At ho etc. (Specif	ome, farm, st	reet, facto	ry, office			(Street and I wn, State)	Number or F	Bural Route Number,
- Le	ours a		29a. Certifier 1	1 Certifying Ph	nysician: To the be	st of my kno	wledge, deat	th occurre	d at the ti	πe, date and place	e, and due to the	cause(s) a	nd manner a	as stated.
DIVISION VICE To the Hoenitel or Attending Physician:	within 24 hours after death.  To the Funeral Director: K  completely filled in by the fi	Medical	(Check only 2 one)	2 Medical Exar	miner: On the basis and manner		ition and/or ir	nvestigatio	n, in my o	ppinion, death occu	urred at the time	, date and p	lace, and du	e to the cause(s)
Ė	To t	Σ	29b. Signature and til		- D.			25	c. Licens					oth, Day, Year)
_			30. Name and address		zi Riz			Print\	MD	62180		007	oper	-29,2007
10	)		Fauzi Riz		400 West	7th S	Street	. Fre	deri	ck, Mary	land 21	701		
\$- h	Sta Registi		31. Date filed (Month	Car Sear 2	007 <sup>32</sup> eg	strar's Signa	8 9	rede	,					

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month DOROTHY 12:45 P M VIRGINIA THOMAS OCTOBER 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 220-28-8076 Days 1 ■ M 2 🖫 f Director 1933 FRED. MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Counfy 10d, Inside City Limits or 28a-f show HEDERICK FREDERIUK 1 ☑ Yes 2 ☐ No MD. other traumatic event, the Medical Examiner must be notified Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or: MANISON ST. 21701 U.S 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Donestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be JONES WEEDON 2 19a. Informant's Name/Relationship (Type. Print) (504) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mPley DR. ROT. B 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2 101 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KEST HAVEN PEM GAR. 11-3-07 FRED MA. 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Lightsee 22. Name and Address of Facility GARY L. Rolling Function to me ST. FRED. MS. 21701 23a. Part1. Enter the Isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner RIGHT VENTRICUlar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CARDIO MYO Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 100m 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an was an autopsy performed? 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0047951 Man 10-26-2007 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUE - TREDERICK A-KAZMI, MD 814 TOLL HOUSE 21701 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

NOV 0 1 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10726/2007 8:33 A.M James B. Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Manor Care Largo If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 **3** M 2 □ F 242-68-9437 09/23/1944 North Carolina Director 63 Usual Residence of Decedent bould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c, City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Springdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9215 Utica Place 20774 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYYes 2 No If Yes, Give Year or Dates: 64-68 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No **Black** Specify ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S.Postal Service Postal Employee or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be in Department of Health and Mental Himportant: If item 27 is marked ott any Injury or other traumatic eveningne. Be Alverna Royster James B. Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9215 Utica Place, Springdale, Maryland 20774 Clarice Thompson/Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Crematory 2. Name and Address of Facility 4 Donation 5 Dother (Specify) 10/29/2007 | Alexandria, Virginia 21. Signature of Funeral Service Licence Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to liminediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine UASCULAR law requires that the death certificate be executed buriat-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1∏ Yes 2 NO director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 7 N 1 | Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Natural 2 ☐ Accident 1 TYes n 24 hours after death.

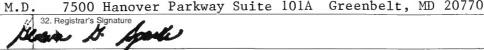
Ie Funeral Director: A

bletely filled in by the fu 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 P ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Cecil D. George, 31. Date filed (Month, Day, Year) OCT 3 0 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

10/29/2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND TITM 31 DEPARTMENT OF HEalth and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Wentling Donald Norval /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 6 Fayette Street If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Apr 5, 1937 Birthplace (State or Foreign Country)
 MD 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Director 214-34-1733 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event the Markle. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Cumberland 1 ☐ Yes 2 ☐ No MD Allegany **Funeral Director** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? **USA** 21502 6 Fayette Street 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ Ko Specify. Specify: Be Completed by 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Tomar Inc. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Lucille (Bucy) Wentling Norval Lamar Wentling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 6 Favette Street Cumberland wife Lucy Wentling 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 11/13/2007 Rocky Gap Veterans Cemetery MD Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature Fineral Service Licensus 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immed te Cause (Final disease or condition resulting in death) **Physician** recurrent non-small /Medical Due to (or as a consequence of) 03/2006 Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an funeral director, page 2: autopsy
performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year)

6

Division or Vital Records, P.O. Box 68760,

Hospital or Attending

State Registrar 31. Date filed (Month, Day,

404 Seton l

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2007

Year)

32. Registrar's Sgnature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Month **Physician** Linda Louise Woofter October 29, 12:14a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Year | If Under 24 Hrs. Holy Cross Hospital Montgomery 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 M 2 F 220-34-8642 Sept. 20, 1939 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 TXNo Director Maryland Montgomery Wheaton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2702 Dawson Avenue 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∏ Yes 2**½** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**x** No Specify: White 1 ☐ Yes 2 🖈 No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Hank Briston Louise Ruth McCurty ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Woofter/Son 2702 Dawson Avenue, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) November 2 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entembrent Parklawn Memorial Park 2007 Rockville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 5 23a. Part1. Et er the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Cardiac Arrest Due to (or as a consequence of): b. Hypotensian Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cachexia 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 201 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 ☐ Inpatient 3[★DQA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760 the certificate Physician: this After Hospital or Attending

as nse for ed by the a detached f sign be page 2 within 24 hours after deatl To the Funeral Director: by filled in completely

**Funeral** 

Director

r 28a-f show notlfied at

"natural", or Items 23a or edical Exaπlner must be i

the Medical than

s 1 and 2 should be filed if Health and Mental Hygic tem 27 is marked other other traumatic event, the marked other

Department of Health Important: If item 27 any injury or other tr

Physician

/Medical

**Examiner** 

Pages 1

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) 3 OCT 2007

our





D52261

October 29, 2007

07-08351 Joan Wirth

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 36688 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 27, 2007 Joan Marie Wirth 0947 hrs **Medical Examiner** c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Olnev Montgomery General Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** reign Country Maryland 219-68-3137 Months Days Hours Director 52 Yrs July 4, 1955 M 2 X F Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2 X No 28a-f show Maryland Rockville or items 23a or 28a-f sho must be notified at once. Montgomery imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland nort of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4913 Melinda Court 20853 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married Yes 2 X No Yes 2 X No specify: Specify.White If Yes, Give Year Widowed 4 Divorced Examiner ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Medical Hallmark 12 Territorial Assistant 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harry Coulter Wolfe Mary Emma Harris Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Richard Wirth, Jr./Husband 4913 Melinda Court. Rockville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State November 2, Parklawn Memorial Park ment ( 2007 Donation 5 Other Specify: Rockville, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Sighature of Funeral Service Licensee Approximate Interval Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be executed Physician/Medical UNPENDED AMENDED #16aperFh10/31/07.BWW.MbCb attending physician or use as the burial x Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown for detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ Yes 2 No 3 Probably 4 Unknown مَ Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy s certificate has b rector, page 2 sh performed? death? ✓ Yes 2 No 2 No 1 V Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Other<sub>4</sub> 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient this 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification 1 V Natural Yes 2 Pending 24 hours after death. Director: I in by the f 2 Investigation Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) To the Funeral D determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 O.C.M.E. October 28, 2007 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus MD.

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month Day Year)

2007

32. Registrar's Signature

07-08099 David Brian Jacol	b W						delible l						jible.				
		I- For State Registrar			ar yrarra		tificate c			Wichta		Re	g. No.	200		3668	3 9
Physicia: Medical Examin		1. Decedent's Name David Br			ite						l N	ate of Deat Ionth Ctober 17	Dav	Year		e of Death 00 hrs	
		4a. Facility Name (i 6327 Bright		n, give street	and numbe	r)		4b. City, Lanh		ocation of [	Death			ounty of Dea			1
Funeral		5. Social Security N		6. Sex	7. A	ge (In yrs. la	ast bi <b>rt</b> hday)	If Und	er 1 Year	If Under 2	24Hrs. 8.	Date of Birt		/YYYY) 9. B	irthplace	•	1
Director	1	Unknov Usual Residence o		1 X M 2	F	33	Yı		ls Days	Hours		May 3	, 197		countryMa	aryland	4
у в виу		10a. State Maryland	10b. County	e Geor	rao!e	10c. City,	Town or Loca	ation	<del></del>				_			nside City Limits Yes 2 X No	1
faryland	ŌL	10e. Street and Nu		e Geor	ge 3	Lam	.iaiii	10f. Zip	Code			10	g. Citizen	of What Co	· ·	res 2 Aivo	$\dashv$
th the N 23a or 7		6327 Brig	htlea						706					d Sta			
death wi	Funeral	11. Marital Status  1 X Never Marri	ed 2 M		Vas Deceder rmed Forces Yes					anic Origin Mexican, P		Yes or No- in, etc.)	- 14.	. Race - Ame White, etc.	erican Ind	ian, Black,	
rs after o	≦.	3 Widowed  15. Decedent's Ed		orced If Yes,	Give Year		1 16a. Decede	Yes 2			od of work	dono		ecify:	White		_
6 172 hou an "nati cal Exa	Completed	Elementary/Seco			ollege (1-4 o					OO NOT us		done	100. Killo	1 of Business	s/iridus(iy		
21215-0036 hald be filed within 7 Mental Hygiene, marked other than e event, the <u>Medica</u>	omo.	17. Father's Name	(First, Middle	, Last)			Deliv	ery			Name (Fir	st, Middle, N		ce1/S	hipp:	ing	$\downarrow$
1215 d be file fental H parked o	B	Theodore					T					tbody					
MD 2 nd 2 shoul alth and M m 27 is m	٩	John Whit			int )							irk, l		or Town, Sta	ite, Zip Co	ode)	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the <u>Nedical Examiner must be notified at once.</u>		20a. Method of Dis 1 Burial 2		n 3 Rei	moval from S	State	Place of Dispo crematory or o	other place	)	1	De 10-26	-2007		ation - City	or Town,	State	7
Baltimore, oermit. Pages 1 ar Department of Hei Important: If ite	}	4 Donation 5 21 Signature of Fu	Other S		/A	Foi	rt Lino				Simp	le Tr					-
	_	23a. Part I. Enter fr	n De	sch.	Mrcd	4	10	)40 R	ockvi	11e F	ike,	Rock	ville	, MD			_
Physician /Medical		failure. List on	ly one cause	on each line		die deali	. Do not enter	trie mode	oi dyirig, s	uch as care	diac or res	piratory am	est, shock,	, or neart		roximate Interval ween Onset and Death	
√ `xaminer		or condition resulti	ng in death)		(or as a con	sequence o	f):						•			· · ·	1
	iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlying Cause	Due to	(or as a cor	sequence o	if):						-				٦
ecuted and transit	Examiner	(Disease or injury t events resulting in	hat initiated death) Last	Due to	(or as a cor	sequence o	if):										٦
an an	dical	UNPENDED			NDED												1
Box 68760, s death certificate be the attending physical of for use as the buried for us		IF FEMALE: 23b. Was decedent past 12 months			. If yes, outo		2 🔲 F	etal death	3	Ectopic p	regnancy			Date of delivenenth	ery Day	Year	7
Box 687 death certific he attending p	ysici	1 Yes 2	No 9 Un	known 4 2	Pregnant Unknown	at time of de	eath 5 (	Other (Spe	ecify)								
tal Records, P.O. Box ciau: The law requires that the death certificate has been signed by the attector, page 2 should be detached for	ģ	Part II. Other sign	fica <b>nt</b> co <b>nd</b> i	tions contri	buting to de	ath but not r	esulting in the	underlyin	g cause giv	ven in Part	I.	23e. Did to				use of death?	7
ords, v require s been si	Completed	-						_			-	24a. Was	an	24b. Were	autopsy f	indings available	<u>,</u>
Recc The lav	Comp									-		perfo	rmed? 2 ✔ No	death'		2 No	
Vital ysiciau: this certif director,	o Be	25. Was case refer examiner?  1 ✓ Yes	red to medica	Hospita	l: 1 Inpa	tient 2	ER/Outpatie	nt 3		of Death (Control of Death (Co	heck only Nursing He		Residenc	e 6 🗸 Ott	ner: Scene	9	$\dashv$
- L	-	27. Manner of Dear	th	ding F	a. Date of Ir (Month Day	njury v,Year)	28b. Time o FOUND:	f Injury		at Work?	Su	. Describe bject har					٦
ivisior I or Attend after death Director:	Certification:	2 Accident 3 Suicide	6 Cou	stigation 2		Injury - At h	0952 hrs ome, farm, str	eet, factor			28f	or Town, S	State)			ute Number, City	+
D Hospital 24 hours Funeral		4 Homicide 29a. Certifier (Check only 1			Specify) S the best of		nily Ige, death occ	urred at th	e time, dat	e and place				manner as s		-	$\dashv$
To the within To the comple	Medical	one) 2 🗸		and m	e basis of ex nanner state		and/or investig		y opinion, oc. License		urred at the	e time, date		te signed (A			4
3		1/	Ones .	11	7. ~	771	0440		O.C.N	00	CME			per 18, 20		,, r our)	
	Ì	30. Name and add					23a) Examiner	111 P	enn Str	et. Balti	imore N	/ID 2120	1				7
	ate	31. Date filed	•		32. Regist	rar's Signat		salta B		- Juli							$\dashv$
Regist	rar		OT	F001	Mille	40 10	100	A CONTRACTOR OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON AND ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON ADDRESS OF THE PERSON A									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 Sophia Walck October 27, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 577-32-7203 78 New York Nov. 5, 1928 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland **Rockville** Montdomerv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14413 Barkwood Drive 20853 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Manager Metal Workers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Sullivan Mary Walsh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick H. Walck/Husband 14413 Barkwood Drive, Rockville, Md 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State November 2, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myo cardial Infarction disease or condition

Physician /Medical Examiner

and

nding physician

certificate be executed

Division or Vital Records, P.O. Box 68760,

permit. Pages 1 end 2 Department of Health a. Important: If Item 27 is any Injury or other trau once.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

Be

ဥ

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene.
77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

P

es the burial-trans ed by the a page Medical Certification: filled in by the

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

or Attending Physician:

resulting in death)	Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):										
that initiated events resulting in death) Last	C										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown			23d. Date of delivery Month Day Year							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Johknown											
-			24a. Was an autopsy performed? 1  Yes 2  ✓								
25. Was case referred to medical examiner?		26. Place of Death (C	heck only one)								
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO		5 Residence	6 □Other (Specify)							
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	M	C. Injury at Work?  1 Yes 2 No	I. Describe how inj	ury occurred							
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, building, etc. (Specify)	office 28f.	Location (Street a City or Town, Sta	nd Number or Rural Route Number, te)							
29a. Certifier 1	ysician: To the best of my knowledge, death occurred a niner: On the basis of examination and/or investigation, and manner stated.	at the time, date and place, and in my opinion, death occurred	d due to the cause( at the time, date a	s) and manner as stated. nd place, and due to the cause(s)							
30h Signature and title of certifier	290	License number	204 D	ato signed (Month Day Voor)							

139793

1814 Poince Philip Dr. Olusy, ms 20832

27,2007

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Segistrar's Signature

Christopher J. Mays, MD

2007

Day, Year)

3

31. Date filed (Month

			For State Registrar	State of Marylan		irtment of F tificate of		Mental Hy	giene Reg. N2 0	07	36691
			Decedent's Name (First, Middle, La.	st)				2. Date of De	eath Day	Vonr	3. Time of Death
	Physici		Christine		h	erne	r	Month		Year 2007	18:42 M
	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)			or Location of Death		4c. County	of Death	
			Johns Hooki	ns Hospit	a)	13a1+i	more (	City			
Т	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth av. Year)	9. Birth	place (State or Foreign
н	Director		185-44-5987	□M 27F 55	Yrs.	Working Days	Tiodio IIIII	NOV. 1			PA.
	p ,		Usual Residence of Decedent  10a. State 10b. County	100 00	y, Town or Lo	antin-					10d. Inside City Limits
	aryla shov	-	AA. DELAW		EN M						1 ☐ Yes 2 ☑ No
	89-f	octo	2027111	616							
	vith th	Director	10e. Street and Number	ice ROAD		10f. Zip Code	342		10g. Citizen of		intry?
	s 23e	E I			0 40.1					<u> </u>	can Indian,
5-0036	be filed within 72 hours after death with the Maryland tal Hyglene.  de Hyglene.  de dother than "netural", or items 23e or 28e-f show other than "netural", or items 24e or 28e-f show event, the Medical Exercitive Protest	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Yas Decedent of F Yes, specify Cuba Yes 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Bla	ck, White	
Ę	2 hor	Completed	15. Decedent's Ed	ducation	16a. Deced	ent's Usual Occup	pation	-t	16b. Kind of B	lusiness/Ir	ndustry
212	within 72 ene. than "ne'	ple	(Specify only highest gra	College (1-4or 5+)			during most of world)	ang	US 6	OVI	
	d wit	no:	Listing in the state of the sta	3	u.	S, NA	<b>ν</b> γ				
and	be filed tal Hygid d other	Bec	17. Father's Name (First, Middle, Last,				18. Mother's Nam			. //	
<u>a</u>		Tol	K. Ralph We	rner			Annal	Marie	, Sche	-1dly	/
Mary	d 2 should th and Mer ?7 is marke traumatic		19a. Informant's Name/Relationship (				and Number or Ru			State, Zi	p Code)
	and allth		MARK Werne				Concor			331	
o O	es 1 and of Healt fitem 2 r other		20a. Method of Disposition  1 Burial 2 Cremation 3	0	cemetery, cren	sition (Name of natory or other plac	ce) ,	Date	20c. Location		0
Ĕ	Pages ment of ant: If it ury or o		'4 □Donation 5 □ Other (Specific	y) ST.T.	homas	The Apo	ostlead.	24,200	76len	Mil	1s Pa
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licer	isee P PP -	22	. Name and Addre	ess of Facility	ARY L.	ROLU	NSF	-UN. 100ME
D —	898		1 Bang X.	poll	110	) WEST	sount si	- FRE	Derun	mo	21701
			23a. Part1. Enter the disease, or com shock, or heart-failure. List only	plications that caused the deat one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a_invasive	muc	oc inf	ection				Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq							- C15(Y)
	Examiner		Sequentially list conditions,	b. DroLon  Due to (or as a conseq	ged	neuti	ropeni	a			3 month
	P	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				,				,
	te be executed ysician and ie burial-transit	am	that initiated events resulting in death) Last	c. refracto Due to (or as a conseq	ry pr	e B cell	lymphob	lastic	leukei	n19	6 months
Ď,	oe exection significant		resulting in deathly cast	Due to (or as a conseq	luence of):		,				
8/60	cate b ohysic the b	dlcal		_ d							
S S	ertific ding p	Me	IF FEMALE:	22e If you gutcome of progra	2001						
Ř	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live birth 2 Feta	ıl death 3 ☐	Ectopic pregnancy	у			ate of deliv onth	very Day Year
j.	the a	ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	ieath 5	Other (specify) _					
7.	v requires that the de been signed by the s should be detached	P.	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlving cause giv	ven in Part I.	23e. Did	tobacco use con	tribute to	the cause of death?
ďŠ,	signe d be	d b		•	J	,		10	Yes 2♥No	3 ☐ Pro	bably 4 Unknown
Records,	r requ	Completed						04- 145-	245	Mara aut	anny findings available
ě	e law has l	ld l						24a. Was		prior to co death?	opsy findings available empletion of cause of
_	(0							1 Tes	2 🗷 No		2 No
Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				
-	Phys rthis raldii	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4   Nursing n		idence 6 Otl		ify)
ב	ding h. After funer	E I	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk?  Yes 2∐No	200. 00001100			
S	deati deati ctor: / the	ica	3 Suicide 6 Could not b		ome farm str		1.00	28f. Location	(Street and Num	ber or Rui	ral Route Number,
DIVISION	or A after Dira	Certification:	4 Homicide determined	building, etc. (Special	(y)	301, 140101), 000		City or To	wn, State)		
	spite ours naral filled		29a. Certifier 17 Certifying Ph	ysician: To the best of my kno	owledge, death	occurred at the til	me, date and place	and due to the	cause(s) and m	anner as	stated.
	To the Hospitel or Attending Pr within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical		niner: On the basis of examina and manner stated.							
	Fo th within Fo th: compl	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	ed (Month	, Day, Year)
	, , , , , ,		+asika A. Wo	orta menicai	DACT	OR RE	=5-00	00	Octobe	r 18	3,2007
1			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)					•
1	P						D North Wol	Fe Street	Baltimor	e Mai	ryland 2128
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	1			,		,
	Registr	ar	Fasika A. Woreta 31. Date filed (Month, Day, Year) NOV 0	I 2001 Bleeve	, A	the same					

DHMH 17 Rev 1/2001

			For State	State of Ma	aryland	-	artment of H <i>rtificate of l</i>		Mental Hy	giene		
	100	19/3	Registrar  1. Decedent's Name (First, Middle, La.	st)		Cel	illicate of t	Jeani	2. Date of De	Reg. No.	2007	3.5693
	Physici: /Medic		Hsien Huey Yang						Month Octobe	er 26	, 2007	11:40 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Dea	th	4c. (	County of Death	
		*	Casey House  5. Social Security Number 6. S	Sex 7 An	je (In yrs. las	st hirthday)	Derwood If Under 1 Year	If Under 24 Hrs	8. Date of Bi		ntgomer	
b	Funeral Director			□M 2 <b>X</b> F	87	Yrs.	Months Days	Hours Min	. (Month, Da	ay, Yea <i>r</i> )	919 Chir	place (State or Foreign Intry)
	pun		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	tor	Maryland Montgome	ry		h Pot						1 ☐ Yes 21 No
	th the or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	intry?
	ath wil	ral	13201 Glen Road				20878				ted Sta	
	72 hours after death with the Maryland natural", or items 23a or 28a-f show itcal Ex. miner must be notiffled at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀		. 13. \	Was Decedent of H If Yes, specify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	)- 1	<ol> <li>Race - Ameri Black, White</li> </ol>	
21215-0036	ours a		3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🙀 No	Specify:			Specify: As:	ian
15-0	"natu	Completed by	15. Decedent's En (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of we	orking	16b. Kir	nd of Business/Ir	ndustry
212	l withir liene. r than the Ma	dwo	Elementary/Secondary (0-12)	College (1-4or 9	5+)		memaker	"/		0,	wn Home	
bu	e filed al Hyg I other	Be C	17. Father's Name (First, Middle, Last	)				18. Mother's Na	me (First, Middle			
ylaı	ould b Ment narked	일	Jing Kui Han						h Chin		····	
Maryland	nd 2 sh ilth and 27 is n r traun		19a. Informant's Name/Relationship (Yvonne Yang (Daug				ng Address <i>(Street a</i>					ip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 ☐ Burial 2 ဩCremation 3 ☐		cer	Metry, crer	sition (Name of matory or other place politan	,	ober 31,		cation - City or T	
altir	mit. P partme sortan / injur		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service 1 cel		1	Crema <sup>1</sup>	COTY  2. Name and Addres		007 eVol Fur			Virginia
m	an land		Max /	The		10	E. Deer	Park Dr	ive, Gai	ther		MD 20877
			23a. P rt1 to the lisease, or community of art fillure. List only							arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate for Final disease or Adition resulting in death)	Metasta Due to (or as			of Unkno	own Prim	ary			
	Examiner		Convention line and divine	h =	a conseque	ince oi).						
	sit ed	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	ence of):						
	xecute and	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of):						
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical E		<b>_</b> d								
	ertifica ing ph e as th	Medi	IF FEMALE:									
Вох	death certi e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ♣ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	death 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deliving Month	very Day Year
P.O.	t the d by the ached	hysi	1 ☐ Yes 2 1 ☐ No 9 ☐ Unknown	9□ Unknown	it time or dea	0						
or Vital Records, F	law requires that the de as been signed by the a 2 should be detached t	by	Part II. Other significant conditions of Hypertension	contributing to death b	out not result	ing in the ur	nderlying cause giv	en in Part I.				the cause of death?
000	aw require s been sig	Completed	Atrial Fibrillati	on					24a. Was			topsy findings available
- B	The ate has page	Jul S						-		ipsy ormed? 2 √ No	death?	ompletion of cause of 2 \sum No
Vita	Iclan: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth		eath (Check only	one)		
ō	ding Phys h. After this ( funeral dir	To	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Inju	ent 2 ∐El ury 2	R/Outpatien 28b. Time of		4 Li Nursing	Home 5 ☐ Res			Hospice
ion	Attending r death. ector: After by the fune	atior	1 Natural 5 Pending 2 Accident investigation		ay Year)	Injury		k? Yes 2 □ No				
Division	or Atte after dea Directo in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	Zoe. Place of m	jury - At hom tc. (Specify)		eet, factory, office	-	28f. Location City or To	(Street and wn, State)	d Number or Ru	ral Route Number,
	Hospital of the hours af Funeral Dittely filled in		29a. Certifier 1X Certifying PI	nysiclan: To the best	of my knowl	ledge, deatl	h occurred at the tir	ne, date and place	ce, and due to the	Cause(e)	and manner as	stated.
	as (V as (I)	ledical	(Check only one) 2 Medical Example Medical Example 1	miner: On the basis of and manner st	of examination	on and/or in	vestigation, in my o	opinion, death oc	curred at the time	, date and	place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	41.6	1	$\sim$	29c. Licens				e signed (Month	
	18		· perencue	VVNO C	V	)		4615		OC COL	oer 29,	ZUU /
			30. Name and address of person who Genevieve Wroblew	The state of the s	,			Suite 1	00, Rock	ville	e, MD 20	)850
	Sta Registr		31. Date filed (Month Day, Year)	32 Registr	rar's Signatu	ire	and I					
	riegisti	aı		1. 18 18 60	and Al	1.54	March 1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36694 For State Amend 19b, perFH, 9873, 11/19/07 TT Certificate of Death Registrar Amend 19b, perFH, 9873, 11/16/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician NORMAN E ADELMAN NOVEMBER 12 2007 11:40 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LORIEN MAYS CHAPEL HEALTH CENTER TIMONIUM BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 03/24/1932 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 160-24-2617 Director 75 Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show be notified at Director 1 ☐ Yes 2 ☑ No MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ould be filed within 72 hours after death with i Mental Hygiene. ŏ items 23a 302 CANTATA COURT APT. 210 U.S.A.

14. Race - American Indian, by Funeral 21136 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 M Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 6 Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Specify 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the SALESMAN INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked WILLIAM Pages 1 and 2 should nent of Health and Men ADELMAN ပ ANNA KORSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
302 CANATA COURT APT. 210 - REISTETSTOWN, MD 21136 19a. Informant's Name/Relationship (Type. Print) BARBARA ADELMAN / WIFE 27 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS permit. Page Department 11/15/2007 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mark 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARIOMYOPATH ISCHEMIC **Physician** Urs disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ardiovascular dispose terio scleratic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical as the ed by the attending detached for use as Box ( IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, diseas 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2. No 1∐ Yes Division or Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 2□ Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ŏ To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

NORMA

J.W.

Registrar

charles St Swt 204/Bacto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) NOV 1 6 2007

			1_ State	ertificate of Health and Mertificate of Death		21111/	36695
			1. Decedent's Name (First, Middle, Last)	Timcale of Death	Reg. I	No.CL O O 1	3. Time of Death
	Physici /Media		EDWARD LEONARI	BUDZYNSKI	Month 08	3 2007	7:07 PM
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Franci		Villa Rosa Nursing Home  5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)	Mitchellville  () If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	eorge
	Funeral Director		215 09 9493 <sup>1⊠ M 2□ F</sup> 91 Yrs.	Months Days Hours Min.	(Month, Day, Yea	916 Mar	yland
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation		1	0d. Inside City Limits
	Many	ţo	MD Prince George Bowie				1 XYes 2 No
	or 28s	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	e 23a	Funeral Director	13114 Oval Lane	20715	7 7	U.S.A.	an India
336	be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. d other than "natural", or iteme 23a or 28a-f show event, the Medical Examiner must be notilined.	δ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
9200-91212	72 hou	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workin	16b	Kind of Business/In	
	within 72 ene. than "nat	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	B	altimore	-
	filed v Hygie other	Be Co	9 17. Father's Name (First, Middle, Last)	Firefighter  18. Mother's Name	(First, Middle, Maid	ire Depa <sub>Gen Sumame)</sub>	rtment
Maryland		To B	Joseph Budzynski	Cather	ine Kos	akowski	
dan,	D1 00 = =			ling Address (Street and Number or Rural			Code)
	1 an Heal em 2		20a, Method of Disposition 20b. Place of Disp	osition (Name of D	owie, MD	20715  Location - City or To	own, State
ē	Pages nent of I int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cri	ematory or other place)		altimore	
Baltimore,	permit. Pages Department of I Important: If Its eny injury or o		21. Signature of Euneral Service Licensee	22. Name and Address of Facility GJ 169 Riviera Dr.		uneral H	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.			na, MD	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition Congestive F	Heart Failure			Onset and Death Weeks
	/Medical Examiner		Due to (or as a consequence of):				
		Jer	if any, leading to immediate Due to (or as a consequence of):	ic Cardiovascul	ar Disea	ase	years
	ocuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c				
8/60,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
200		edical	d				
C. Box	w requires that the death certif been signed by the attending should be detached for use as	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
λ, T	law requires that the as been signed by th 2 should be detache	by Ph	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc	o use contribute to the	ne cause of death?
ğ	equire en sig ould b	ted t	Chronic Obstructive Pulmonary	Disease	1 ☐ Yes	2 □No 3 □ Prob	ably 4 Kunknown
Vital Record	The la	Completed			24a. Was an autopsy performed 1 Yes 2 🛣	prior to co death?	psy findings available mpletion of cause of 2 No
VIE	iding Physician: th. : After this certifics funeral director,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death			
ō	Phy this ald	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	THE SEL DON 4 AND INVESTIGATION	ne 5 Residence 8d. Describe how in	6 ☐Other (Specification)	γ)
	ending aath. or: Aft he fun	atio	1 Matural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
DIVISION	at or Attence after death Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 2	8f. Location (Street City or Town, St.	and Number or Rura ate)	l Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, a nestigation, in my opinion, death occurre	nd due to the cause ed at the time, date a	(s) and manner as s and place, and due to	lated. the cause(s)
	To the within To the compl	¥e	29b. Signature and little of certifier	29c. License number	29d. I	Date signed (Month,	Dey, Year)
)			> My Jung my	032261	No	vember	12, 2007
1	0		30. Name and address of person who sompleted cause of death (Item 23a) (Type Richard Feldman, MD 9500 Anna	·	7.4 T 1	300	20706
-il	Sta	te	31. Date filed (Month, Day, Year)  32. Rigistrar's Signature	polis Rd Suite	M4 Lanr	nam, MD	20706
	Registr	ar	NOV 1 6 2007 Rolling St. A.	gerte)	par em		

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11 -12-2007 3:21 A Mary Margaret Breach /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Residence-3400 Parkfalls Drive Baltimore Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12–15–1946 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 215-48-2717 60 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2x No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be It 21236 3400 Parkfalls Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank G. Malone Mary Magdaline Haut ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. Breach, SR (Husband) 3400 Parkfalls Dr. Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Pk. 11-15-2007 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINONA netastatic Physician un Two Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has breaking the rector, page 2 s autopsy performed? or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 □Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 ☐ Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Funeral C completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

3

State Registrar 31. Date filed (Month, Day, Year)

oted, cause of death (Item 23a) (Type, Print)

1/14 65-69 Nonth Charles Hreat Towson, Manyland

32. Registrar's Signature

November 14, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** PM 2007 Norma H. Brescia Nov /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 129 Arundel Road Pasadena Anne Arundel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕅 F 093-14-9526 83 12/20/1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-4 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Anne Arundel Pasadena Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 129 Arundel Road 21122 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 【X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schlesler Mary Peter Schmidt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 Arundel Road, Pasadena, Nicholas R. Brescia (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 13 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 X Burial 2 ☐ Cremation 2007 Nakemont Cemetery Davidsonville, Maryland 4 Donation 5 Other (Specify) 21. Signatur of Funeral Socice licentee 22. Name and Address of Facility Stallings Funeral Home, P.A. ., Pasadena, MD 21122 3111 Mountain Rd., 23a. Part 1 Enter the obease, or complications a caused the geath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LORUNARY **Physician** HERUS CLERATIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Se Lentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed CAWCGR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 Dano 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director; After the etely filled in by the funera After t (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of perso, w o completed caus of death (Item 23a) (Type, Print) Ft Smallwood Red Stel Pasadera Mis 21122 Michael F. Garahy, M.D. 3651 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Statem of Macria ft / 6893 arment of Health and Mental Hygiene 36698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day of Year **Physician** Henry Bryant November George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bauhmake City

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Hospital · 0] Baltimore 5. Social Security Number 246 214-20-6360 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ▼M 2 □ F NC 01 02 Director 80 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 √Yes 2 No Baltimore Completed by Funeral Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 U.S.A. 2811 Boarman Ave 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Y Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry lementary/Secondary (0-12) College (1-4or 5+) Park Sausage Co. Laborer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Duncan Idell Brown George W.King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20720 9112 Myrtle Ave, Bowie, Maryland Marvin Bryant-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Vet 11/16/070wings Mills, Md Garrison Forest 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
March F/H West 21 gn ture of Funeral Serv Licensee 4300 Wabash Ave Baltimore, Md Thompson 21215 23a. Part. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) Intership **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065718

State Registrar

known as

SINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

32 Registrar's Signature

PENDLI

NOV 1 6 2007

HARITHA

31. Date filed (Month, Day, Year)

HOSPETAL OF BALTIMORE

			. For	State of	Marylan	d / Depa	artment of H	lealth a	and Me	ntal Hyg	iene			
			1 - State Registrar			Cer	tificate of	Death		R	eg. No:)	107	366	PP
E	Dharaiai	8	1. Decedent's Name (First, Middle, Las	st)					2	. Date of Deat Month	h Day	Year	3. Time of	Death
46.5	∘Physici ∞/Medic		Benjamin	James		В	oler		N	lovembe	r 12,	2007	11:40	) PM
	Examir		4a. Facility Name (If not institution, give	street and numb	er)		4b. City, Town, o	r Location of	of Death			ity of Death		
- 6			Shady Grove Adven				Rockvill		Od blan I o			gomer		
Ŀ	Funeral		5. Social Security Number 6. S	ex XDM 2□F	Age (In yrs.	Yrs.	Months Days	Hours	Min.	. Date of Birth (Month, Day,	Year)	9. Birth		Foreign
	Director		239-31-3650 Usual Residence of Decedent		35				[ N	lay 29,	19/2		NC	
	/land low at		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City	y Limits
	Man Fied	ţċ	NC Guilfor	d	Gr	eensbo	ro						1 ☑ Yes	2 □ No
	or 28g	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Cou	ntry?	
	th will		2522 C-16th Stre	et			27405				US	SA		
	r dea	Funeral	11. Marital Status	12. Was Deced Armed Ford	es?	S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Specit n, Puerto Ric	ty Yes or No- can, etc.)		ace - Ameri lack, White,		
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at	by F	1 Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 If Yes, Give			1 ☐ Yes 2 🖾 No	Specify:			Spec	oify: B.	Lack	
Ö	hour tural'	d be	15. Decedent's Eq	Year or Date	88:	16a Deced	dent's Usual Occup	ation		- 1	16b. Kind of			
5	in 72 n "na Medic	Completed	(Specify only highest gra	de completed)	1 F.)	(Give	kind of work done OO NOT use retired	durina mos	st of working				,,,,,,	
712	with siene	E	Elementary/Secondary (0-12)	College (1-4	for 5+)	Custo	mer Serv	ice			Telema	arket:	ing	
פ	0 7 0 8	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (I	First, Middle, I	Maiden Surna	ame)		
<u> a</u>	should be nd Mental marked o	To E	Billy Eugene Bo	1er				Ch	risti	ne Howe	11			
Maryland 21215-0036	2 should be f n and Mental H is marked of raumatic ever		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural f	Route Number	, City or Tow	n, State, Zi	o Code)	
	and ealth m 27		Christine Howell	Boler-M		2522	C-16th	<u>Stree</u>						
Baltimore,	. Pages 1 and 2 should be ment of Health and Ments tant: If item 27 is marked lury or other traumatic e		20a. Method of Disposition  12□ Burial 2 □ Cremation 3 □	Removal from St	ate Pio	lace of Dispo emetery, crer dmont	sition (Name of natory or other place	ce)	Dat	e	20c. Location	ı - City or T	own, State	
<u>E</u>	permit. Page Department o Important: If any Injury or once.		4 □ Donation 5 □ Other (Specif			orial	Park	i	11-17-		Greens		NC	
ä	Depar Mpor Iny In		21. Signature of Funeral Service Ocer	isee	00	- 1	2. Name and Addre							
	TD = 40		OSC BOLL WAR ALL STATES	runa			200 N O'					, NC	27405	
			23a. Pari 1. En r the disease, or com lock, or leart failure. List only mediate Cause (Final	one cause on ea	ch line.	i. Do not ent	er the mode of dyn	ig, suci as	cardiac or i	espiratory arr	#SI,		Approximate Interval Betwood Onset and D	veen leath
	Physician /Medical		disease or condition resulting in death)	a. Sepsi										
	Examiner				r as a conseq	uence of):								
-9	200	آة ا	Sequentially list conditions, if any, leading to immediate	b. Aids Due to (o	r as a conseq	uence of):								
d	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Course Closease or Injury that initiated events	Hiv								-		
) O	exec an and rial-tra		resulting in death) Last	Due to (o	r as a conseq	uence of):								
8760,	ficate be executed physician and s the burial-transit	dical		⊷d										
Õ	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:										_	
. Box	leath certific attending p I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Feta	Ideath 3	Ectopic pregnanc	У				Date of deliv Month		'ear
0	ne de the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9∏Unknov	nt at time of d vn	eath 5∟	Other (specify) _							
Д.	w requires that the de been signed by the should be detached		Part II. Other significant conditions of	ontributing to dea	th but not resi	ulting in the u	nderlying cause giv	en in Part f	1.	23e. Did tol	pacco use co	ontribute to	the cause of de	eath?
Records,	signe d be	Completed by	Cirrhosis	3		J	, , ,			1 □ Y	es 2 No	3 ☐ Pro	bably 4 □U	Jnknown
Ö	v requ	etec					<del></del>			24a. Was a	n   241	h Woro aut	aney findinge	available
Æ	he lav e has ge 2	ם								autops	sy med? 2 A No	death?	opsy findings a ompletion of ca	use of
Vital	sician: The certificate harector, page		25. Was case referred to medical					26 Place	o of Dooth /	1□ Yes Check only on		1 🗆 Yes	2□ No	
	ıysicia iis cert direct	To Be	examiner? 1 ☐ Yes 2]{ No	Hospital: 1 Xin	oatient 2 🗆	ER/Outpatien	nt 3 DOA Oth	er.		e 5 ☐ Reside		)ther (Spec	if <sub>V</sub> )	
Division or	g Phy er thi eral o		27. Manner of Death	28a. Date of		28b. Time of				d. Describe h		- ' '	-97	
0	ath. r: After re funera	atio	1 Natural 5 Pending 2 Accident investigation	1	Day (eai)	Пјигу		Yes 2□	No					
<u>                                      </u>	il or Attend after death Director: A	tific	3 Suicide 6 Could not be 4 Homicide determined	26e. Place C	finjury - At ho	ome, farm, str	eet, factory, office		28	f. Location (Si City or Town	reet and Nur n, State)	nber or Rui	al Route Num	ber,
Ō	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely illied in by the funeral director,	Certification:		4										
	Hosp 4 hou Fune ely fil	ical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exar	niner: On the bas	sis of examina	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date ar opinion, de	nd place, an ath occurred	d due to the c	ause(s) and late and plac	manner as e, and due	stated. to the cause(s	.)
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)  29b. Signature and title of certifier	and manne			29c, Licens				9d. Date sign			
	7. ₹ 5 8	-	255. Signature and title order the	101	MAD MA	OH	64				NOV th			007
,	$\cap$		SO Name and add and	nompleted	of docts (to	1 F [ .		0 1 (			ACACN		, - ~	
	7		30. Name and address of person who Kapil Parakn, M.D.				cal Cent	er Dr	., Roc	ckville	, MD	20850		
	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Signa	ture								
	Regist		NOV 1 6 200	17	and Sh	100	منطا							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Month **Physician** 9 Paul Brennan, Sr. Daniel 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Talbot Memorial Hospita Easton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 16, 19 Year)
9. Birthplace (State or Foreign Country)
1918 West Virginia 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 T F 88 Director 217-10-0688 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Caroline Goldsboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 24215 East Cherry Lane 21636 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 □ Nol 939 If Yes, Give Year or Dates: 1942 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 'natural', 3 ☐ Widowed 4 X Divorced Completed Department of Health and Mental Hygiene important; If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Dan's Pizza Shop Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mark Brennan Mary Jane Rohrbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James J. Carr (Son) 24215 East Cherry Lane, Goldsboro, MD 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/13/07 4 □ Donation 5 Other (Specify) Lahmansville Cemetery Lahmansville, WV 22. Name and Address of Facility
Schaeffer Funeral Home 21. Signature of Funeral Service Licensee Lannes Dellmen 11 N. Main St., Petersburg, WV 26847 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Resperator Days /Medical Due to (or as consequence of: Examiner NOS Dreumoner Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Renal failure. Days burial-transi Acute Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) a linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Asbeltosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should Lymphocytic leukemia. 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2000 1∏ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 🚜 0 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 ₩atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

that the death certificate be executed and Box 68760 physician ed by the a detached f P.O. Division or Vital Records, certificate has this After t Hospital or Attending within 24 hours after death.

To the Funeral Director: A

show

Saltimore, Maryland 2121

Registrar

KOLLI RAMESH 31. Date filed (Month, Day, Year) NOV 1 5 2007

29b. Signature and title of certifier

KRamel

(Check only one)

2195 washington 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

The State of

29c. License number

Street-

D 66441

Easton

29d. Date signed (Month, Day, Year)

21601

November

MO

2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 13, 2007 12:14 A M Donald Richard Buchanan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Rethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 17 M 2 □ F Director 404-09-7202 Oct. 20, 1920 Ohio 87 Usual Residence of Decedent within 72 hours after death with the Maryland a or 28a-f show the notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🛛 No Directo Maryland Montgomery North Bethesda 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a dical Examiner must b Completed by Funeral 5809 Nicholson Lane #1602 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced WWII the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Vice President Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be 1 Mental I s 1 and 2 should be f Health and Mental item 27 Is marked o other traumatic eve Samuel Buchanan Grace Slater 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Shady Elm Mews, Gaithersburg, MD 20878 Jack Richard Buchanan/Son permit. Pages 1 and Department of Healt Important: If item 2: any injury or other t other 20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State November 16 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Euneral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cholangitis Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Respiratory Failure Due to (or as a consequence of): Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy detached for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 X Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No page 2 perforn 2X No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 1 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date şigned (Month, Day, Year) -m'D13/200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2011 Brendan James Carmody, M.D. 8600 Old Georgetown Rd., Bethesda, MD 20814 32 Registrar's Signature 31. Date filed (Month, Day, Year) State SE HELD Registrar

DHMH 17 Rev 1/2001

Baltimore,

300

han ac

O.

Vital

ö

Sion

			For State Registrar	State o	of Maryland	Depa Cer	rtment of F	lealth a	and Me		giene (	107	36702
	Physic		1. Decedent's Name (First, Mide	Butle						2. Date of Dea Month	th Day	o <sup>Year</sup>	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institution Keswick Multi	on, give street and nu		ic.L	4b. Cily, Town, o					nty of Deatl	
	Funeral Director		5. Social Security Number 218-18-4359	6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under Hours	OFE 24 Hrs. Min.	8. Date of Birtl (Month, Day	, Year)	9. Birth	nplace (State or Foreign untry)
	Maryland f show	ō	Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, T		nore.						10d. Inside City Limits 1 12 Tes 2 □ No
	with the la or 28a-	Direct	10e. Street and Number	radac A . I		14411	10f. Zip Code				10g. Citizen o		untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at ances.	by Funeral Director	11. Marital Status  1 Never Married 2 Ma	12. Was Deci Armed Fo rried 1 Yes If Yes, Gir	edent Ever in U.S. prces? 2/17/40 ve	lt.	Vas Decedent of H Yes, specify Cuba	ispanic Ori in, Mexican Specify:	gin? (Spec n, Puerto R	city Yes or No- lican, etc.)	14. R	lack, White	ncan Indian, a, etc.
Maryland 21215-0036	hin 72 hours s. in "natural" Medical Ex	Completed b		d Year or D  nt's Education est grade completed)  College (1	10	Sa. Decede	ent's Usual Occup kind of work done of O NOT use retired	ation	t of workin	g	16b. Kind of	121	ndustry
nd 21;	al Hygiene al Hygiene d'other the	Be Com	17. Father's Name (First, Middle		1-401 5+)	Do	mestic		er's Name	(First, Middle,		vate ame)	2.
aryla	should band Ment and Ment a marked	7	Charles 19a. Informant's Name/Relation	Fox ship (Type, Print)	1	9b. Mailing	Address (Street	and Numbe		Route Number		vn, State, Z	ip Code)
	s 1 and 2 f Health i Item 27 I		Joyce William 20a. Method of Disposition	•	20b. Place	of Dispos	Loch (Name of	1	n Bh		imare 20c. Location	MD n - City or T	21218
Baltimore,	permit. Page Department o Importent: If any injury or once.		1 Desurial 2 Cremation 4 Donation 5 Other (	Specify)	State	Mem	atory or other place original Par Name and Address	s of Facilit	11.19 Val	-2007 Shock	Baltin	nore	MD noral services
m E	8858		23a. Part I. Enter the disease, of	or complications that c	mo136	3 40	905 Yor	( lhoo	0 B0	altimor	e, Mi	212	Approximate
	Physician /Medical Examiner		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a01	or as a consequence	sse	ve D	210	-not z	'n			Interval Between Onset and Death
	and Il-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	or as a consequence	v	ina						Jean
68760,	ificate be executed g physicien and as the burial-transit	edical		d									
.O. Box	s that the death certific ned by the attending F e detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come of pregnancy irth 2   Fetal dea ant at time of death own		Ectopic pregnancy Other (specify)			-		Date of delived	∕ery Day Year
Records, P.	The law requires that the tite has been signed by the bage 2 should be detache	þ	Part II. Other significant condition	ons contributing to de	eath but not resulting	in the und	derlying cause give alletes	en in Part I.		23e. Did to		•	the cause of death?
		Completed	mellitus, i	ntracri	anial h	einov	vliage		·	24a. Was a autops perform	n 24t y ned? 2 No	D. Were aut prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
or Vital	ysic is ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 ER/0	Dutpatient	3□ DOA Othe	_		Check only on e 5 ☐ Reside	22	ther (Speci	ify)
DIVISION O	al or Attending Ph s after death. I Director: After th d in by the funeral	Certification:	27. Manner of Death  1	gation	h, Day Year)	. Time of Injury			28	d. Describe ho			
<u> </u>	urs after of rail Directing in Direction by		4 Homicide determ	nined 28e. Place buildir	of Injury - At home, ng, etc. (Specify)			142		City or Town	n, State)		al Route Number,
	To the Hospital or a within 24 hours atter To the Funeral Direction completely filled in b	edical	29a. Certifier 1 Certifyii (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann		ge, death o and/or inve	occurred at the timestigation, in my op	e, date and inion, deat	d place, an h occurred	d due to the call at the time, d	ause(s) and r ate and place	manner as a, and due	stated. to the cause(s)
	To To Com	Σ	29b. Signature and title of certifie	Las Re	ly, a	2	DAS		_		9d. Date sign		
	B		30. Name and address of person	Ramo	of ath (Item 23a	(Type, Pr	rint) where St.	Ba	Chi	neve	ms =	2120	2, 2007
	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	egistrar's Signature	sele	,	-					

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. All Copies Are Legible. Assure of Mental Hygiene 10 17

36703

				State of Marylar			of Death	Wientai i i	Reg. No.	1 3	5 / 0 3
1	•	7/4	1. Decedent's Name (First, Middle, Le	st)				2. Date of I		Year 3.	Time of Death
	Physici Medic		Flossie	(00P4	er			//		007 5	550pm
0	Examir	- 2	4a Fecility Name (If not institution, giv	e street and number)	0		4b. City, Town, or	Location of De-	ath 4c. County	of Death	
			Manor Care	Koland	Yark	ider 1 Ye		nore	Dieth	O Diethulana	Ctata as Fasaina
4	Funeral Director		5. Social Security Number 6. S 249.44-4705 1 Usual Residence of Decedent	ex 7. Age (In yrs.	Yrs. Mont					South	State or Foreign
	yland		10a. State 10b. County	10c. Ci	ty, Town or Location						side City Limits
	the Marylar 28a-f show	cto	MD	B	altimo	re				1	XYes 2 □ No
	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. markad other than "netural", or items 23a or 28a-f show umetic event, the Medical Evaminar must be notified a	To Be Completed by Funeral Director	10e. Street and Number 5110 Baltimor	e Nat'l Pi	Ke 109.	Zip Cod	21229		10g. Citizen of V	Vhat Country?	
	items items	nue	11. Marital Status	12. Wes Decedent Ever in U Armed Forces? 1 ☐ Yes 2 N No If Yes Give	I,S. 13. Was De	ecedent of specify C	of Hispenic Origin? (Suben, Mexican, Pue	Specify Yes or I to Rican, etc.)	No- 14. Rac Blac	e - American Inc k, White, etc.	dian,
21215-0020	nours afte	d by F	1 Never Married 2 Married  Widowed 4 Divorced	Year or Dates:		s 21/1			Specify	DIAC	K
15-	n 72 l	lete	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's U (Give kind of life. DO NO	Isual Oc work do Tuse rei	cupation ne du <i>ning m</i> ost of wo tired)	orking	16b. Kind of Bu	isiness/industry	
212	withi iene. than	шо	Elementary/Secondary (0-12)	College (1-4or 5+)	Home I	leal	h Aid		Heals	thear	6
	il Hyg other	e C	17. Father's Name (First, Middle, Lest)	1 0	Dervie	3 1	18. Mother's Na	me (First, Mida	lle, Maiden Sumam		
<u>lai</u>	ould be filed with Mental Hygiene arkad other that atic event, the	10 E	Elisha Kober-	tson, Sr.			tre	ne Ca	impbe	.[ ]	
, Maryland	permit. Pages 1 and 2 should be filed within 72 hours aft Deperment of Health and Mental Hygiene. important: if them 27 is marked other than "netural", or any injury or other traumetic event, the Medical Examples.		19a. Informant's Name/Relationship ( Sylvia Roberts)	n (Niece)	376 Ft	L		oad, L	quiens,	SC2	9360
altimore,	Pages 1 nent of Ha nt: If iten rry or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition (cometery, crematory)	Name of or other	p/ace)	1 1 16 07	20c. Location -	City or Town, S	MD
Balti	permit. Pag Depertment important: if any injury o		21. Signatur of Foreran Service Licen			and Ad	dress of Facility Cr	ematro	_ ^	ices	1779
	液		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications thet caused the deat	th. Do not enter the	node of	dying, such as cardia			Appr	roximate val Between
**	Physician /Medical		Immediate Cause (Final disease or condition	a. CORUNAL)			D158			Onse	et and Death
	Examiner	je l	resulting in death)		or as a consequence						
dy	ecuted no transit	amin	Sequentially list conditions,	b. Due to (c	or as a consequence	of):				1	
68760,	be executed sician and buriel-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						1	
	lificate g phys	Aedic	resulting in death) Last	Due to (c	or as a consequence	of):				i	
Вох	eath cer ettendin for use	an/l		d							
	e deal	Sici	Part II. Other significent conditions of	ontributing to death but not res	sulting in the underlying	ng cause	given in Part I.	23b. Di	d tobecco use co	ntribute to the	ceuse of death?
P.0	res that the de signed by the e be detached f	Completed by Physician/M	ATRIAL FI	BRILLATION				1[	☐ Yes 2 1 No	3 Probably	4 🗌 Unknown
ds,	signe d be	db						24a. W	as an autopsy	24b. Were au	topsy findings
S	v raquire been si should t	ete							rformed?	available complet of death	e prior to ion of cause
Re	vysician: The law nis certificate has b I director, page 2 s							1	Yes 200 No		2□ No
ta	an: T tificat tor, pa	Be C	25. Was case referred to medical				26. Place of De	ath (Check onl			
f V	ysich is cer direc	2	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA	Other: 4 Nursing	Home 5□Re	sidence 6 Oth	er (Specify)	
0	ding Phys h. After this funeral d	ä	27. Manner of Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. li	njury at Work?	28d. Describ	e how injury occur	ed	
Sio	Attending Physician: r death. sctor: After this certifica by the funeral director,	catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М		☐ Yes 2☐ No				
Division of Vital Records,		edicai Certification: To	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fac fy)	ctory, offi	се	281. Location City or 7	n (Street and Numb Town, State)	er or Hurai Hou	re Number,
	e Hospital or 24 hours efte e Funeral Dir pletely filled in	edicai	29a. Certifier 1 ► Certifying Ph (Check only one)	ysician: To the best of my kno niner: On the basis of exemine and manner stated.	owledge, death occur etion and/or investiga	red at the tion, in m	e time, date and plac ny opinion, death occ	e, end due to th urred et the tim	ne cause(s) and ma e, date and place,	inner es stated. and due to the d	cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier				ense number		29d. Date signe		
			0 - 1	$M \cdot D$		DO	059107		11-14	- 200	7
	2		30. Name and address of person who c			18	REASTERS	To sad	mo 2	1136	
	Sta	te	31. Date filed (Month, Day, Year)	22. Registrer's Signa	ature		KUIN CIN	1000			
	Registr		NOV 1 6 2007	32. Registrer's Signa	forte)						
DH	MH 16 Rev 6/95	;	146 A T A COR.	1	*						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** VICENTE MELICOR CENIZA /Medical NOVEMBER 2007 6:52 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Air Harford 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min M 2 F Director 220-43-7097 Jan. 22, 1929 Philippines Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2√ No Funeral Director Maryland Harford Fallston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or 2902 Sedgefield Court 21047 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 5 1 √Yes 2 No Completed by Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Filipino 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Physician other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental em 27 is marked o Aqustin (nmn) Ceniza ျှ Esperanza (nmn) Melicor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2902 Sedgefield Ct., Fallston, Maryland 21047
ace of Disposition (Name of Date 200. Location - City or Town, State <u>Epifania Ceniza / Wife</u> permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition  $12-5^{-0.07}$ 1 → Burial 2 □ Cremation 3 → Removal from State 4 □ Donation 5 □ Other (Specify) Angelicum Garden of Angels Cebu City, Philippines Funeral Service, Licen 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coma /Medical Due to (or as a consequence of): Examiner rebral Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ardiac Arrest Preumonia Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No ancer una the Hospital or Attending Physician; nin 24 hours after death. 25. Was case arred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending Investigation 1 TYes 2 □ No 2 Accident Director: 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral E 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature

30. Name and

filed (Month, Day, Year)

NOV 1 6 2007

dress of person who completed cause of death (Item 23a) (Type, Print)

M. D. 500 L Registrar's Signature

0056296

500 upper Chesapeake Dr. Bel 4ir, mD 21014

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a, 27 per dr., g878;131;1616/07e3hb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 11:00 a<sup>M</sup> 2007 Estella I. Crook /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Halethorpe Baltimore 4205 Washington Blvd. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 □ M 2 🕏 F 1942 Jan. **Director** 120-34-8114 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at 1 ☐ Yes 2 ☐ No Director MD Halethorpe Baltimore 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ortant; If Item 27 Is marked other than "natural", or Items 23a or Injury or other traumatic event, t<mark>he Medical Examiner must be 1</mark> USA 4205 Washington Blvd. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No white Specify Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 St Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Bar 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy important: if Item 27 is marked other any Injury or others. 17. Father's Name (First, Middle, Last) Be Nelson Pearce Estella Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7906 Winterbrook Ct., Severn, MD 21144 Ms. Sandra Clarke/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Stevensville, MD 4 □ Donation 5 □ Oth (Specify) <u>Chesapeake Cremation</u> 21. Signature Funeral S 22. Name and Address of Facility rvice Licensee Singleton Funeral and Cremation Services; M01411 | 2nd Ave. SW, Glen Burnie, MD 21061

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardio Vascelar diseas **Physician Probable** porternun Tue to or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner OBUCCO death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. vision or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2□No 25. Was case referred to medical examiner?
1 √Yes 2 No Be 26. Place of Death (Check only one) funeral director Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death to the Funeral Director: the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) euld not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide ö Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the 29d. Date signed (Month, Day, Year) 29b. Signature an P cause of death (Item 23a) (Type, Print) Chrise MD 21075-30. Name and add 50 shington

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

32. Registrar's Signature

			1 - For State Registrar	-	odrtinent of Health and I ertificate of Death	Mental Hy	giene Reg. No. 2 N	7 20706
-			Decedent's Name (First, Middle, Last)			2. Date of De	eath 200	3. Time of Death
	Physicia /Medic		FRANK CHEAT	HAM JR.		Novembe	Day Ye er 10 200	5.4
	Examin	er	4a. Facility Name (If not institution, give street and I	number)	4b. City, Town, or Location of Death	n	4c. County of D	eath
	Funeral		1314 STONEWOOD RD  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	BALTIMORE  (y) If Under 1 Year   If Under 24 Hrs.		N/A th 9.	Birthplace (State or Foreign
	Director		<b>225-24-</b> 224-25-8585 1	82 Yrs.	Months Days Hours Min.	FEB. 2	iy, Year)	Country) IRGINIA
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
	Maryla f shored at	o	MARYLAND N/A		ALTIMORE			1 ⊠Yes 2 □ No
	r 28a- notifi	Director	10e. Street and Number		10f. Zip Code	T	10g. Citizen of What	Country?
	th with		1314 STONEWOOD RD.		21239		U.S.A.	
	er dea tems	Funeral	Armed	ecedent Ever in U.S. 13 Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No o Rican, etc.)		merican Indian, /hite, etc.
30	be filed within 72 hours after death with the Maryland Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 1 Aye If Yes, 3 Widowed 4 Divorced Year or	es 2 □ No Give r Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: B	LACK
5-0036	2 hou latura Ical E		15. Decedent's Education	16a. Dec	cedent's Usual Occupation		16b. Kind of Busine	
2	within 7 ene. than "r he Med	Completed	(Specify only highest grade complete Elementary/Secondary (0-12) College	(Gr ife (1-4or 5+)	ve kind of work done during most of wor DO NOT use retired)	rking		
2	filed w Hygier offher the		12th grade  17. Father's Name (First, Middle, Last)	TAX	XIE CAB DRIVER	no (Eiret Middle	PRIVAT  Maiden Surname)	E
and	ould be f Mental I larked of	To Be	FRANK CHEATHAM SR.			A CHEATI	,	
a Z	2 should and Men Is marke aumatic	ř	19a. Informant's Name/Relationship (Type. Print)	19b. Ma	iling Address (Street and Number or Ru			e, Zip Code)
е, маг	rt 23 mg		Margaret A. Cheatham/Da		14 Stonewood Rd.,	Balto.,	Md., 2123	9
more	0 = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City	
	permit. Pag Department Important: any Injury o		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee			20-07		, VIRGINIA
n n	Depa Impo any I		Dallara Chrown		22. Name and Address of Facility VILLIAM C BROWN CO 1206 W NORTH AVEN			
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of	it caused the death. Do not e n each line.	enter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ypertensiv	e nephropa	tny		years
	Examiner		Due :	t fr as a consequence of):				•
9.	sit sd	iner	Sequentially list conditions, hard, reading to Interest to Cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a nonsequence of):				
Ž	xecute and al-tran	Examiner		to (or as a consequence of):				
58/50,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical E						
	nd bh	Medi	IF FEMALE:					
X R R	ath ce	jan/l	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of Month	delivery Day Year
j.	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Un		5 ☐ Other (specify)			,
ις. Τ	requires that the death certi een signed by the attending nould be detached for use a	by Pr	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did t	obacco use contribut	e to the cause of death?
ecords	equire					1 🗆	Yes 2 No 3 □	Probably 4 Unknown
e S	e 2 sh	Completed				24a. Was	psy prior	autopsy findings available to completion of cause of
VITAI IN	n: The licate r, pag						ormed? deatl	
<u> </u>	s certii	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpati	26. Place of Dea		one) dence 6 □Other (S	Page 16 d
סר	ng Phy ter this neral o	<b>-</b>	27. Manner of Death 28a. Da	ate of Injury 28b. Time Injury Injury	of 28c. Injury at		how injury occurred	вреспу)
vision	eath. tor: Al	catic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
<u> </u>	al or Al	Certification:	determined 200. Pla	ace of injury - At home, farm, s ilding, etc. (Specify)	street, factory, office	28f. Location ( City or To		r Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or property.	Medical (	(Check only 2 Medical Examiner: On the	the best of my knowledge, de e basis of examination and/or anner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	Vithi To th	Ž	29b. Signature and title of certifier		29c. License number		29d. Date signed (M	
1			your	)	17030		November	13 2007
_	8		30. Name and address of person who completed ca	ause of death (Item 23a) (Type (70 / A		SON MO	21204	
	Sta Registr		31. Date filed (Month, Day, Year) 32	Registrar's Signature	and 8			

		State of Maryland / Dep	artment of Health and M		•				
		1 - State Registrar  C6  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg	. No 2007	36707 3. Time of Death			
Physic /Med		DUROND COATES		NOVEMBER 10, 2007 5:00p M					
Exam		4a. Facility Name (If not institution, give street and number)  LORIEN NURSING CENTER	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A				
Funera Directo	-	5. Social Security Number  6. Sex  7. Age (In yrs. last birthda)  219-82-3755  1 ☑ M 2 ☐ F  46 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth 3–14–196	(ear) 9. Birth	place (State or Foreign			
ъ		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits			
Maryla a-f shor	ctor	MD. N/A BALTIM				1 □XYes 2 □ No			
with the a or 28	Funeral Director	10e. Street and Number 1601 N. BRUCE ST. APT 5	10f. Zip Code 2 1 2 1 7	100	g. Citizen of What Cou USA	ntry?			
death	inera		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White				
Deficient (Fig. 1) Wall yield (A. I. I.)—0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any nique.	þ	1 ☐ Never Married 2 ☐ Married 1 Å ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 Å Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: BL				
in 72 ho	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16	6b. Kind of Business/II	ndustry			
CIC ed withi ygiene. ner thar t, the N	Comp	Elementary/Secondary (0-12)	ABORER		JANITORIA	AL			
Id be file fental Hrked oth	To Be	17. Father's Name (First, Middle, Last) WILLIAM COATES							
i, Ivial yla and 2 should i ealth and Men n 27 is marke ner traumatic			ling Address (Street and Number or Run						
es 1 an of Heal		20a. Method of Disposition 20b. Place of Disposition cemetery, or	ematory or other place)	Date 20	c. Location - City or T	own, State			
it. Pages intment of intrant: If ite		4 □ Donation 5 □ Other (Specify) GARRISON	FOREST VETERANS 1			ILLS, MD.			
permit. Departr Imports any inju			R. Name and Address of Facility RED 1721–27 N. MONROE			YLAND 21217			
Dhysisian		23a. Part1 Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac	or respiratory arres	rt,	Approximate Interval Between Onset and Death			
Physician /Medical Examiner	1	resulting in death)	OWEL OBSTRU	ACT TO	·/				
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	OWEL UBS/10	γ					
be executed sloian and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):							
ate be ex hysician and the burial	<u>a</u>				-				
certificand and ing plants as the sas	n/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	/ery			
he death the atte	Physician/Medic	in the past 12 months?	□ Ectopic pregnancy □ Other (specify)		Month	Day Year			
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to				
w requires to been signed should be contact.	leted			1∐ Yes 24a. Was an	2 No 3 Pro	obably 4			
The la	Completed			autopsy performe 1∐ Yes 2	prior to c	ompletion of cause of			
ysiclan: ysiclan: s certific	To Be	25. Was case referred to fledical examiner?  1   Yes 2   No	Othor	h <i>(Check only one)</i> ome 5∏ Besiden	ce 6 □Other (Spec	ify)			
fing Phy After thi		27. Manno of Death  ☐ Natural 5 ☐ Pending (Month, Day Year)  ☐ Natural 5 ☐ Pending (Month, Day Year)	of 28c. Injury at	28d. Describe how		.,,,			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,			
spital o		29a. Certifiler Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
the Ho hin 24 h the Fur	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.  29b, Signature and title of certifier	investigation, in my opinion, death occur		te and place, and due				
5 × 5		29b. Signature and title of certifier	A57727	250		, Day, Teal)			
IVA		30. Name and address of person who completed cause of death (Item 23a) (Type	13 Waldram	Wash	'e bond	1121234			
s	itate	31. Date filed (Month, Day, Year)  32. Degistrar's S/gnature	13-1000-000	J - 0 VOC		, , , , , , , , ,			
Regis	trar	NOV 1 6 2007 Sugar 15	nerde!						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12 2007 1:20p. 11 /Medical 4a. Facility Name (If not institution, give 3902 Emm. 4c. County of Death 4b. City, Town, or Location of Death Examiner ALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☑ M 2 ☐ F 78 29 06 15 Jamaica Director 218-70-6262 Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at X☐Yes 2☐No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Jamaica 21215 3902 Emmart Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: à Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital Porter 12th grade na permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Smith ဂ James Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3902 Emmart Ave, Baltimore, Md Eva L. Duncan-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 11/17/2007 Randallstown, Md 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Interval Between Immediare Cause (Final disease or condition esultir g in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed RONIC 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

be executed burial-tran and Box 68760. physician the attending for use P.O. ed by the a detached f Records, cate has been sig , page 2 should b certificate has Division or Vital this

72 hours after

filed within 7 I Hygiene.

Maryland 21215-0036

Baltimore,

funeral After To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -WUSU MD. 5051

State Registrar

Medical

31. Date filed (Month, Day, Year)

4 Homicide

29a. Certifier



and manner stated.

DHMH 17 Rev 1/2001

3

			For State Registrar	State of M	aryland		artmen rtificat					jiene 19g. No.	Z III I	36	709
	Physici		1. Decedent's Name (First, Middl	e, Last)							2. Date of Dea Month	th Day	Year	3. Time o	
	/Medic		Samuel	Α.	Davis	3					October	т		1311	P M
	Examin	er	4a. Fecility Name (If not institution	n, give street and number)			4b. City,	Town, or	Location	of Death		4c.	County of Deat	th	
			Saint Agnes Ho 5. Social Security Number		ge (In yrs. la:	st hirthday)		timo		24 Hrs.	8. Date of Birth	,	Q Bird	thplace (State	or Foreign
	Funeral Director		212-90-9857	1182 M 2□F	44	Yrs.	Months		Hours	Min.	(Month, Day	, Year)	962 Cle	ountry)	
			Usuel Residence of Decedent								DCC. 2.		702 010	verand	,01110
	how	_	10a. State 10b. County		10c. City,	Town or Lo	calion							10d. Inside C	
	Ba-f e	Director	MD		Balt	imore	2								2 No
	with th		10e. Street and Number				10f. Zip	Code			•	10g. Citi	zen of What Co	ountry?	
	e 23g	Funeral	1203 Valley Br	ook Court, A		12		21150		oio? (Spo	ofu Vos or No.		JSA 14. Race - Ame	nican Indian	
	ther d	Fun	11. Marital Status  1 ★ Never Married 2 Mar	Armed Forces?	?	. 13.	If Yes, spec	offy Cuba	n, Mexicar	n, Puerto I	ecify Yes or No- Rican, etc.)		Black, Whit		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or fleme 23a or 28a-f ehow ent, the Madical Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give			1 🗆 Yes	2⊠ No	Specify:				Specify: B	Lack	
<u>က်</u>	72 ho	Completed		l's Education st grade completed)		16a. Dece	dent's Usua	al Occupa	ation during mos	t of workii	na	16b. Ki	nd of Business	/Industry	
2	hen.	npl m	Elementary/Secondary (0-12)	College (1-4or	5+)	lite.	kind of wo DO NOT us		)		•		_	_	
2	lled w tygies ther ti	S	12 17. Father's Name (First, Middle,	Last			Por	ter	10 Mothe	ar's Namo	(First, Middle,		od Serv	rice	
and	2 2 2 2	Be	Alvin Davis	Last)							a Towne		Sumame)		
Maryland	should be filed with and Mental Hygiene amarked other the umatic event, man	ဥ	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	na Address	(Street a			I Route Numbe		r Town. State.	Zin Code)	
<u>8</u>	and 2 sealth arm 27 is		Thelma Davis				_				t, Balt	-		21150	
Baltimore,	- T = 2		20a. Method of Disposition		cor	ce of Dispo	sition (Nar	ne of			ate		cation - City or		
Ē	permit. Pages Department of I important: If its eny injury or or once.		1 Surial 2 Cremation 4 Donation 5 Other (S		Edw	ard G	rove	and piece		11-0	07-07	War	renton,	NC	
<u>=</u>	rmit. porta y inju		21. Signature of Funeral Service	Licensee	OGII			d Addres	s of Facilit	ty Bo	yd's Fu				
n	89 = 8		ylun D	eadle			149	H011	and l	Bland	l Rd., W	larr	enton,	NC	
			28a. Parl 1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each !	d the death. ine.	Do not ent	ter the mod	e of dying	g, such as	cardiac o	r respiratory ari	est,		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition a. Athrosclerotic Coronary Vascular Disease								Onset and	Death			
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):									
		4	Sequentially list conditions.  Due to (or as a consequence of).												
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.												
a î	ite be executed lysicien and ne burial-transit	Exa	resulting in death) Last	C. Due to (or as	a conseque	ence of):									
9	ate be executed hysicien and the burial-transit	cat		d											
RG O	at the death certifica by the attending ph tached for use as th	Med	IF FEMALE:	1	-uprogramme		5007.5			25507163		T			
ROX	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal d	eath 3 Ectopic pregnancy					23d. Date of delivery  Month Day Year			Year	
o.	the a	ysic	1 Yes 2 No 9 Unknown 9 Unknown												
2,	2 2 9	Ph							23e. Did to	bacco u	se contribute to	the cause of	death?		
ďs,	w requires t been signe should be o	d by							es 2{	es 2 No 3 Probably 4 🛣 Unknown					
Hecord		lete	End Stage Rer	al Disease							24a. Was a	an	24b. Were au	utopsy findings	available
	sician: The law r certificete has be irector, page 2 sh	Completed							perfor	autopsy prior to comperformed? peath?		completion of 2□ No	cause of		
VItal		BeC	Hypertension 25. Was case referred to medica	1					26. Place	of Death	(Check only or		10.100	2010	
o	> % 0	10	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpati	ent 2⊠E	R/Outpatier	nt 3 DC	)A Othe	er: 4 □ Nu	ırsing Hor	lome 5 ☐ Residence 6 ☐ Other (Specify)				
	A 0 0								28d. Describe how injury occurred						
<u>s</u>	Attending r death. sctor: After by the fune	cat	2 Accident investigation M 1 Yes 2 No					204 1							
UNISION	or A after Direc	Certification	4 Homicide determ	tc. (Specify)	y - At home, farm, street, factory, office (Specify) 28f. Location (Street and Number or In City or Town, State)					urai Houle Ivul	поег,				
	spital ours nerai filled		29a. Certifier 1⊠ Certifyii	ng Physician: To the best	of my know	ledge, deat	h occurred	at the tim	ne, date an	nd place, a	and due to the o	ause(s)	and manner as	s stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st	of examination	on and/or in	vestigation	in my op	oinion, dea	th occurre	ed at the time, o	late and	place, and due	to the cause	(s)
	withir To the Comp	ž	29b. Signature and title of certifie	" 1-11	2	20	290	. License	number		2	29d. Dat	te signed (Mont	h. Day, Year)	
			· /w	~ ~ ~	L //	11	D	0053	312			Octo	ber 30	2007	
	\		30. Name and address of person								-				
			Michelle Heng 31. Date filed (Month, Day, Year,	geler, 900 C	aton A	Avenue	e, Ba	ltime	ore,	MD					
	Sta Registr		MOVE T R	32. Regist	iai a Signatu	SOM	82.00								
			Fill 0 15 8 13 6	TANK WASSESSEE		car.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 9, 2007 8:00 AMM Annaweiss Dezube /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Montclair Manor Fulton if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Jan. 23, 1 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 🗆 M Jan. Alabama 523-44-9047 87 1920 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes 2X No Director Fulton MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or Items 23a or the Medical Examiner must be 11805 Wayneridge Street 20759 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Howard County College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Teacher 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If Item 27 Is marked other 1 any Injury or other traumatic event, the any Injury or other traumatic event, the second to the traumatic event to the traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Velma Rachel Corley Carey Davis Elder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7370 Hopkins Way Clarksville, MD 21029 Dona Dezube / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 11/17/07 Hillcrest Cemetery Boaz, AL 22. Name and Address of Facility Carr Funeral Home 21. Signature of Funeral Service Licenses Box 8, Gunnersville, AL 25976 P.O. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on early line. Approximate Interval Betwe 23a edia Cause (Final sease r condition Umm19 **Physician** disease r conditio resulting in death) /Medical as a consequency of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed. and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buna Physician/Medical 23c, If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No. 24a. Was an autopsy perform certificate 1□ Yes 2 Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or macro.

Within 24 hours after death.

To the Funeral Director: After this c 1 ☐ Yes 21440 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gorbak MS 62. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 1

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2007 /Medical 4c. County of Death Eacility Name (If not institution, give street and 4b. Cim Town, or Location of Death Examiner -IMURA TMURE If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Injury or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) To Be 19a. Inform nt's Name/Relationship (Type. 7 int) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 515759 20a, Method of Disposition 20b. Place of Disposition (Name o cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) 21. Signatur / Funeral ic Lice Approximate Interval Between Onset and Death Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediat Cause (Final **Physician** HNC REAL disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Donknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. 2 110 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 1 A Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 'Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a Certifier 1 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Greene Street BALL, mure MD 31. Date filed (Month, Day, Registrar 2007 DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygien 36712 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November **Physician** 11, 2007 Dolores E. Ferenc 8:25 p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9527 Holiday Manor Rd Nottingham Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 215-34-8992 Director 70 09-24-1937 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic avant, the McCloal Examinar must be notified at 1 Yes 2 No Directo Maryland Baltimore Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9527 Holiday Manor Rd 21236 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) tother than " Elementary/Secondary (0-12) 12 College (1-4or 5+) Court Clerk US Federal Court 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill thenf of Health and Mental H tant: If item 27 Is marked otl William L. Swinson Dolores Nagel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Ferenc (Son) 9034 Naygall Rd Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 11-16-2007 Baltimore, MD 22 Name and Address of Facility Schimunek Funeral Homes, Inc. 21. Signature of Funeral Service Licensee famo 9705 Belair Rd Nottingham, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE VITCUMATOID /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/MedIcal use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant been signed by the atten should be detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2☐No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2.2 No 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number m m oMarille 16 VOVEMBER 12, 200+ 30] Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 5901 CHAYLES Street Huan North 31. Date filed (Month, Day, Year)
NOV 1 6 2007 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death NOVEMBER Day 14, 2007 **Physician** HOWARD D. FLEMING 12:50pM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 8345 MINDALE CIRCLE APT A RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. 5-3-1933 6. Sex 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** MARYLAND 218-28-1731 74 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD. BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8345 MINDALE CIRCLE APT A USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12)
-12permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier importents: If Item 27 is marked other the eny injury or other treumstic event, this once. LABORER KESSTER'S BAKERY 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame, Be THELMA COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA\_RICHARDSON(DAUGHTER) 704 S. BEECHFIELD AVE. BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State GARRISON FOREST VETERANS 11-21-2007 OWINGS MILLS, MARYLAN 5 □Øther (Specify) 4 Donation JONATHAN D. HIBNERWame and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature q Funeral Service Lice 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 art1/Enter the disease, or complications that caused the death lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit the death certificate be executed Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours attar death.

To the Funeral Director: Aftar this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No ٩ 1 Tyes 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 24 hours after death. 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 310 OLD COURT 31. Date filed (Month, Day, Year) State 6 200 Registrar

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

U(Le(Li 7, OPaighe094, NO

Year.

2007

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 0 00 3 7-0 6 6

29d. Date signed (Month, Day, Year)

61880 tun Hill 2d# 701 0 ton Hill, no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08604 State of Maryland / Department of Health and Mental Hygiene Rosie Greenleaf Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 5, 2007 1139 hrs **Medical Examiner** Rosie Greenleaf 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel Crofton 1710 Bargers Road Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign c**Marxyl**and Months Days Hours Min Sept 3 1912 95 Director 218-32-5494 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. Gambrills Maryland Anne Arundel **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21054 1710 Bargers Rd. 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces Never Married 2 X No Yes Specify: Black 2 X No specify: Yes 3 X Widowed If Yes, Give Year Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Private Family Domestic 6th 0 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ۵ Physician /Medical caminer er To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

ansit	To Be Completed by Physician/Medical Examin
٤١	7
e burial	Medic
ا ۽	5
e a	7
ñ	<u> </u>
টু	ď
eral director, page 2 should be detached for use as the burial - transit	yd Vr
pe i	7
plnous	) of of
2	3
pag	٥
director,	Bol
era	F

Be	Dennis Wilson	De1	Della L. Carter								
	19a. Informant's Name/Relationship (Type, Print )	19b.	(Street and Num	eet and Number or Rural Route Number, City or Town, State, Zip Code)							
	Thomas Greenleaf(Son) 1710 Bargers Rd. Gambrills, Md. 21054										
1	20a. Method of Disposition  20a. Method of Disposition  20b. Paravel from State  20c. Location - City or Town  20c. Paravel from State  20c. Location - City or Town  20c. Location - City or Town  20c. Location - City or Town  20c. Location - City or Town										
1	1 X Burial 2 Cremation 3 Removal from Stat	11	_9-07   Gambrills, Md.								
	4 Donation 5 Other Specify:										
	21. Signature of Funeral Service Licensee		Withame and	Agree of Pacifity	Sons	Mortu	ary, P.A.	0.1			
15	LArry Reese, MOO483 (per DVR)						, Md. 214				
	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.				ardiac or	respiratory arres	t, snock, or neart	Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)  a. Atheroscler  Due to (or as a consection)		iovascular	r disease							
d	Conventielly list conditions b.										
ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consect	quence of):									
Ē	Cause. Enter Underlying Cause (Disease or injury that initiated							<del> </del>			
Ха	events resulting in death) Last Due to (or as a consec	quence of):									
를	d	) 27 M	E 0076 2	77.700 mm			<del></del>				
g	X UNPENDED X AMENDED #21, perFH	a, 27, penyi .(873, 11	/16/07 'TT	74/06 11							
ğ	IF FEMALE: 23c. If yes, outcome	e of pregnancy	20/0/				23d. Date of delivery				
an/	23b. Was decedent pregnant in the past 12 months?	2	Fetal death		c pregnar	псу	Month D	ay Year			
ij.	1 Yes 2 No 9 Unknown 9 Unknown	ime of death 5	Other (Spe	ecify)							
ķ	1 Yes 2 No 9 Unknown 9 Unknown			i in D	net I	23e Did toh	pacco use contribute to	the cause of death?			
Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death	but not resulting	in the underlying	g cause given in P	aiti.		2 No 3 Prob				
pa			···			24a. Was a	n I 24b. Were au	topsy findings available			
et						y prior to o	prior to completion of cause of death?				
Ē						perform 1 ✓ Yes 2		es 2 No			
ပ္	25. Was case referred to medical			26.Place of Death	(Check o	only one)					
		nt 2 ER/OL	tpatient 3	DOA Other	Nursing	g Home 5 F	Residence 6 V Other	: Scene			
۵	1 ✓ Yes 2 No Tapates  27. Manner of Death 28a. Date of Injul						now injury occurred				
on:	1 X Natural 5 Pending (Month, Day, Yo	ear)	, ,	1 Yes 2	No						
2 Accident Investigation   28e. Place of Injury - At home, farm, street, factory, office building, etc.   28f. Location (Street and Number or Rural Route								ral Route Number, City			
ijij	3 Suicide 6 Could not be 28e. Place of Inj	rm, street, tactory	y, office building, e	eic.	ate)	mai riodio riambor, eny					
Medical Certification: To	4 Homicide determined (Specify)										
ਛ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
dic	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Me	29b. Signature and title of certifier	29	Jc. License numbe	r		29d. Date signed (Month, Day, Year)					
	1 AR WWW.		O.C.M.E. November 6, 2007				07				
	Panelle Fouthall mis										

DHMH 17 Rev 1/2001 **OCME 2006** 

Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

NOV 0 8 2007

Pamela E. Southall, MD

31. Date filed (Month,

Assistant Medical Examiner

distrar's Signature

DHMH 17 Rev 1/2001

State Registrar

NOV 1 6 2007

State of Maryland / Department of Health and Mental Hygiene

Physi /Med Exam

Funera

Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatte event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar	Cer	tificate of	Death		Reg. No. U	3 1	30111		
cian lical	1. Decedent's Name ( <i>Eirst, Middle, L</i> ast) Eloise Olivia Hanna				2. Date of Dea		o¥9₹17	3. Time of Death 10:20 a M		
iner	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, o	Spring		4c. County Montg				
! '	579-50-2697 1□M 2⊠F	n yrs. last birthday) 70 Yrs.	7.0 Months Days Hours Min (Month Day Year)				9. Birthpla Countr Penns	ace (State or Foreign Y) Ylvania		
	Usual Residence of Decedent  10a. State 10b. County 1		10	d. Inside City Limits						
ector	1.50	Oc. City, Town or Loc Silver Sp	ring			1 □Yes 2 No				
Funeral Director	3122 Gracefield Road Apt T06		10f. Zip Code 20904			10g. Citizen of What Country? USA				
		li li	Was Decedent of H f Yes, specify Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	ify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White				
Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4	16a. Decedent's Usual Occupation (Give kind of work done during most of workir life. DO NOT use retired)  Homemaker			vorking	l 16b. Kind of Business/Industry Own Home				
To Be Co	17. Father's Name (First, Middle, Last)  Egesto Ligi	ne)								
	19a. Informant's Name/Relationship (Type. Print) Charles Hanna/husband				Rural Route Number					
	20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, cren Chesapeak	natory or other pla		Date /14/2007	20c. Location - Beltsvi				
	21. Signature of Funeral Service Licensee  Mod  Modureum	7002		£	pp Funera			n Svcs.		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Hypoxic Encephalopathy  Due to (or as a consequence of):  Approximate Interval Between Onset and Death 12 days									
	Due to (or as a conditions Cardiac P	ulmonary A	Arrest							
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	consequence of):								
lical E	d.									
Z Nec	IF FEMALE:					T				
Completed by Physician/I	23c It vas outcome nt	☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	y			te of deliver onth E	y Day Year		
d by P	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t		tribute to the	e cause of death?		
nplete					24a. Was	an 24b.	Were autop	osy findings available inpletion of cause of		
ြီ					12 Yes		death? 1 ☐ Yes 2	2X No		
Be	25. Was case referred to medical examiner?		100		Death (Check only o	ne)				
은	1 ☐ Yes 🛣 No Hospital: 1 🗖 Inpatient				g Home 5 ☐ Resi			)		
ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day 1)  2 Accident investigation	(ear) 28b. Time of Injury	Wo	ryat rk? Yes 2 ∐ No	28d. Describe	now injury occur	red			
Certification:	3 Suicide 6 Could not be determined 28e. Place of injury building, etc.	r - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tou	Street and Numl vn, State)	er or Rural	Route Number,		
Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	xamination and/or inv	n occurred at the ti vestigation, in my	me, date and pl opinion, death o	ace, and due to the occurred at the time,	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)		
X	29b. Signature and title of codifier	Sun	29c. Licens D2409			29d. Date signe 11/8/20		Jay, Year)		
	30. Name and address of person who completed cause of dea Mark Parkhurst, MD 3110, Grace		r e	Spring	MD 2000/					
tate trar	31. Date filed (Month, Day, Year) 32/Begistrar' NOV 1 6 2007	s Signature	STIVET	ANT THE	HD 20304					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** HAtcher 2007 13/SAMM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** MediCAL CENTER BALTIMORE BALTIMORE VA Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 6. Sex **Funeral** XXM 2□F 412-24-0344 Director 03/10/1924 Tennessee Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Baltimore Directo Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 960 Renfrew Street 21221 U.S.A. 14. Race Funeral 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No 1943— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) Wire/ Assembly 8 |Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Hatcher Lula Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hatcher (Wife) 960 Renfrew Street, Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Holly Hill Mem. Gard. 11/17/2007 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 Fire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final diseas or condition resulting in death) **Physician** Stecke 6 DAYS /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner requires that the death certificate be executed anding physician and use as the burial-transit Division or Vital Records, P.O. Box 68760 After t within 24 hours a To the Funeral C To the Hospital

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

page 2 s Medical

29b. Signature and title-of certifier )e

(Check only one)

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDNORTH GREENE STREET BALLIMORE, MD 2401 Himee Bennis ma

and manner stated.

31. Date filed (Month, Day, Year) NOV 1 6

32 Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 367 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200<sup>rea</sup> Physician Haywood Lucille 8:49a 1.1 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA. Baltimore J.H.H. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ₩ F 78 216-24-9728 ۷a. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Baltimore Director Md. NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA 1108 N. Luzerne Avenue Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "natural" ~ " any injury or other traumatic event." 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Travel Agent Self-employed NA 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Η. Lee Ricks William Henaretta ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22857 Redwood Drive, Richron Park, III. 60471 19a. Informant's Name/Relationship (Type. Print) Nola Wallace Niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Owings Mills, Md. Garrison Forest Vet. 11-15-07 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East Baltimore, Md. 21202 1101 E. North Ave. 7 B la 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician o Cardia /Medical Due to 1 r as a consequence of) Examiner OMNar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to for as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the use as t attending p for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Do 51 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No Completed paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe Lower Mul 2 No 2 No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 ☐ Yes 6 ☐Other (Specify) Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0061485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklik Sq. Drive 13UShra I-AL-A22acci, MD, 9103 Franklik Sq. Drive 3 31. Date filed (Month, Day, Year) NOV 1. 6 32 Registrar's Signature State 2007 Registrar

death with the Maryland Baltimore, Maryland 21215-0036 al Hygiene.

the burial-transi and Division or Vital Records, P.O. Box 68760, attending physician for use as the burial been signed by the should be detached cate has funeral after death filled in by within 24 hours a

Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3:15 P M 2007 Hibbard Nov. 14, Helen Sema /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8041 Fair Breeze Drive Anne Arundel Severn 6. Sex If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 ☐ M 2 🖾 F California 49 Director 530-70-8460 10/09/1958 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐Yes 2 No Director Anne Arundel Maryland Severn 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 'natural", or Items 23a or dical Examiner must be i United States 8041 Fair Breeze Drive 21144 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Japanese/ Specify Specify: þ 3 Widowed 4 Divorced Samoan Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Accountant Private Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ Eli Sau Sau Yoshiko Okubo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 Is or other tra Brian M. Hibbard/Husband 8041 Fair Breeze Drive Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State injury 4 □ Donation 5 □ Other (Specify) Arundel Crematory 11/16/2007 Odenton, Maryland 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signa pe of Funeral Service Licenses 1411 Annapolis Road Odenton, Maryland 21113 uanita Homes 23a. Part, Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ENAL FAILURE 20 MONINS /Medical ue to (or as a consequence of) **Examiner** Diabetes Melli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Nesidence 6 □Other (Specify) ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manney stated. (Check only one) 29c. License number thle of certifier 29d. Date signed (Month, Day, Year) 29b. Signature an D0018089 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 GREENWAY CTR DRIVE Greenbelt MI POLLAR mi 31. Date filed (Month, Day, Year NOV 1 6 32. Registrar's Signature Year) State 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Αм Laura Agnes Howard November 10 2007 9:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 800 Winhall Way Silver Spring Montgomery Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F 83 **Director** 578-28-2004 October 31, 1924 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Neal Drive 20850 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: White 3 NWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) a Francis Joseph Darnall Mary Catherine MacDermott 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Howard / Daughter 1010 Neal Drive, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran's
Cemetery at Cheltenham 20a. Method of Disposition November 20. 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 21. Signatur Rockville, Rockville, M01473 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Breast Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed sician and burlal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s 2 🔯 No 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other:  ${}_{4}\square$  Nursing Home  ${}_{5}\square$  Residence  ${}_{6}$  MOther (Specify)  $Son^{\dagger}s$  Residence Hospital: မှ 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MP Loars D16619 November 14, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Corazon Soares, M.D. 8200 Professional Place, Suite 104, Landover, Maryland 20785
31. Date filed (Month, Day, Year) 6 2007 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death Month Ven Be **Physician** /Medical 4b. City, Town, or Location of Death **Examiner** General Hos towend If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Birthplace (State or Foreign Country), 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🔀 F 228-01-09/0 Director SINIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 11 Yes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 5. GRUNDY 2122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status orces:
2 No Army 1/⊈Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HILLMen GAR. Nov 20,2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses CONKING ST BALLO Approximate Interval Between Onset and Death r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest f only one cause on each line. 23a. Part1. Enter the dis Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consec Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran-Due to (or as a co Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2□ No 1∐ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of contifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzan Abdo 5005 Signal Bell lane Clarksulle MD 1gnas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician NOVEMBER 13, 2007 9:30  $P^{M}$ VYTAU KEZENIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 23, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □**X**M 2 □ F 215-30-4614 Lithuania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Alaska Anchorage Anchorage Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or any injury or other traumatic event, the Medical Examiner must be r 99517 USA 2303 Chilligan Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ark of Maryland Peace Worker 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Galinis Jonas Kenenis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2303 Chilligan Drive, Anchorage, Alaska 99517 niece Audre Karasa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore City, MD. 15, 2007 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) precuences /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 2 No Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 14 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar DAVID DUNN

31. Date filed (Month, Day, Year)

6 2007

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division or Vital

BEL AIR, MD.

615 W. MACPHAIL ROAD

32 Registrar's Signature

21014

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Maryland / Dep	artment of Health and M rtificate of Death	ental Hygiene	7 1 1 1 1 1 1 1 1 1 1 1 1
			Registrar  1. Decedent's Name (First, Middle, Last)	Timodio of Dodin	2. Date of Death	3. Time of Death
	Physicia	an	Pierre George Kieffer		November	
	/Medic Examin		4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	L. Admini		Brocke Grove Rebubilitation and Nursing	Sandy Spring		Montgonery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	Director		128-22-2057 1\(\overline{\text{TM}}\) \(\overline{2}\) \(\overline{\text{F}}\) \(\overline{85}\) \(\overline{75}\).		Nov. 1, 19	New York
	D .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits
	shon	5				1 ☐ Yes 2 🙀 No
	he M	Directo	Maryland Montgomery S  10e. Street and Number	andy Spring 10f. Zip Code	10g. Ci	itizen of What Country?
	with		18131 Slade School Road	20860	IIn	nited States
	eath	Funeral		Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
	tter d	표	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		Rican, etc.)	Black, White, etc.
5-0036	urs a	by	3 ⊈Widowed 4 □ Divorced If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 🛣 No Specify:		Specify: White
2	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. A class of that than "natural", or itams 23s or 28s-f show a class than "natural", or itams 23s or 28s-f show awant, the Madical Examiner must be notified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing	Kind of Business/Industry
2	ithin nan "	nple	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) nical Engineer		nemical anufacturing
2	led w lygier har th	S	17. Father's Name (First, Middle, Last)		e (First, Middle, Maider	
and	Ibe fi	Be			Elise Metz	
Maryland 2121	s should be filed within and Mental Hygiene. s markad othar than * surnatic avant, In a Mar	٦ و	Theophile Kieffer  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	ing Address (Street and Number or Run		
<u>⊠</u>	d 2 sho th and th sin traum			)5 Redbridge Ct., (		1
ē,	ges 1 and 2 should t of Health and Men if itam 27 is marka or othar traumatic	i	20b. Place of Disposition		Date 20c. L	Location - City or Town, State
9	Pages nent of I int: if it: iry or o		1 Burial 2 MCremation 3 Hemoval from State Montgon		007 Be	ethesda, Maryland
saltimore,	permit. Page Department of Important: if any injury or once.		21 Signature of Funeral Service Licensee	22. Name and Address of Facility Roll	pert A. Pum	nphrey Funeral Home
m	Per Per Per Per Per Per Per Per Per Per		Loper Luck M01498	Rockville, Inc., 30 Rockville, Maryland	00 West Mor 1 20850	itgomery Ave.
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition BACTERIAL P	AIGONUSC		Onset and Death  7 DAYS
	/Medical		resulting in death)  a. Due to (or as a consequence of):			
	Examiner		Sequentially list conditions.			
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury			
	and and I-trans	Examiner	that initiated events resulting in death) Last C			
8760,	ate be executed thysician and the burial-transit	E E				
387	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d			
Вох 6	leath certifica attending ph d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
ă	that the death cer ed by the attendir detached for use	clar	in the past 12 months?  4 Pregnant at time of death	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	t the d by the tached	hys	9 Unknown			
ر. ت	w requires that been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
ğ	en sig	pa	SENILE DEMENTIA OF THE	ALTHEIMERS	1 Tes	2 No 3 ☐ Probably 4 ☐ Unknown
၁၁	has be	Completed	TYPE		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
œ —	The ate h	Com			performed? 1 ☐ Yes 2 🖾	
ita	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	Othor	th (Check only one)	
£	Physic this c	J.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat  27 Manner of Death 28a, Date of Injury 28b, Time		ome 5 Residence 28d. Describe how inj	
Ä	Attanding Physician: if death. actor: After this certifically the funeral director.	lo	1 Natural 5 ☐ Pending (Month, Day Year) Injury		200. 2000. 20 10 10 11,	.,
Sic	death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,			and Number or Rural Route Number,
Division of Vital Records,	after Dirac	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Sta	I(e)
	To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier Check only (Check only 40 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place	and due to the cause	(s) and manner as stated.
	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	<		Many ATTENDING PHYSI		120	VEMBER 13, CCC)
20	11		30. Name and aldress of person who completed cause of death (Item 23a) (Typ	ede School Road	andy Son's	9. Maryland 20860
بد ا			(SPACE Brooke Huffman, M.) 18106 )(31. Date filed (Month, Day, Year) 32. Registrar's Signature	anschool Pond		11.000
	Sta Regist	ate rar	NOV 1 6 2007 December 18	Apada		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. 2007 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Mabe1 Ε. Kennon November 9, 2007 11:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Arcola Health and Rehab Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Min. Davs 1 □ M 2 🕅 F 89 23, 1917 Maryland Dec. Director 578-10-4747 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County works 10a. State ns 23a or 28a-f shov 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 901 Arcola Avenue 20902 United States Funeral 14. Bace - American Indian. items ; 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Examiner 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ō 1 ☐ Yes 2 💢 No Specify: Specify: White à 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) 12 than College (1-4or 5+) Hygiene. Bookkeeper Department Store filed marked other artment of Health and Mental Hyg ortant: If Item 27 is marked other Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Edwards Hatti Garner 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria L. Miller/Daughter 5319 Jaquima Drive, Angels Camp, California altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery
Mausoleum 20c. Location - City or Town, State Nov. 20, 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or oth Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 □ Donation 5 🛛 Other (Specify) Entombment 2007 21. Signature of Funeral Service License 22. Name and Address of Facility Robert A. Rumphrey Funeral Home, Bethesda-Chevy Chase, Inc 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (clistass of injury Due to (or as a consequence of) Examine be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 5 ☐ Other (specify) 4 ☐ Pregnant at time of death ed by the a P.O. 9□Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Cerebrovascular Accident, Hypertension, 1 Tes 2 No 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dysphagia, Demetia Advanced, Failure to Thrive, 24a. Was an page 2 s autopsy performed? Yes 2 X No Comfort Care 1□ Yes Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Tes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A filled in by the ft 2 Accident death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier youn D53367 November 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Ave. #1-17, Silver Spring, MD Shyamsundar Rajan, M.D. 32. Fegistrar's Signature 31. Date filed (Month, Day, Year) State 16 2007 Registrar

DHMH 17 Rev 1/2001

	1	For State Registrar				iviai yiai		artment of rtificate o			Reg. No. 🤈 🖺	0.7	20720	
		Decedent's Name	e (First, Middle	e, Last)						2. Date of De		UI	3. Time of Death	
Physician		Frieda	,		tsche	3				11/14	$/2^{Day}$	Year	3:15 A <sup>M</sup>	
/Medical		4a. Facility Name (I						4b. City. Town	or Location of Dea		4c. County	of Death	3.13 11	
Examiner		Genesis					Lane	Balti			Anne	Arı	undel	
- Funeval		5. Social Security N		6. Sex			last birthday)	If Under 1 Yea	r If Under 24 Hrs	8. Date of Bir	th	9. Birth	olace (State or Foreign	
Funeral Director		217-12-	9970	1 □ M	2 <b>F</b>	9	91 Yrs.	Months Day	s Hours Min	11713	/1916	Cou	MD	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	-	10a. State	10b. County Anne	λ <b>κ</b> 11:	ndo1		ity, Town or Lo	Location 10d. Inside City L  more 1 Tyes 2						
or 28a-f st be notified Director	-	10e. Street and Nu		AI U.	idei		Jarcin	10f. Zip Code			10g. Citizen of What Country?			
Die Die				an ah	Doná	1			26-1953		U.S.		,	
r items 23a niner must Funeral	-	449 Car	AGT DE			lent Ever in U	J.S. 13.			Specify Yes or No			can Indian,	
item ner r		<ol> <li>Marital Status</li> <li>Mever Marr</li> </ol>	ied 2 Marr		Armed Ford	ces?	,,,,	Was Decedent of Hispanic Origin? (Sport If Yes, specify Cuban, Mexican, Puerto		rto Rican, etc.)	Blac	ck, White,	etc.	
xami by		3 Widowed		- 1	If Yes, Give Year or Dat	9		1 ☐ Yes 2 🗹 N	o Specify:		Specif	v: Wł	nite	
ai E			15. Deceden	t's Educat	on		16a. Dece	a. Decedent's Usual Occupation  (Give kind of work done during most of working			16b. Kind of B	usiness/Ir	ndustry	
n "ng Mediy	-	(Spec	cify only highes	st grade co	College (1-	Aor Eu	(Give	e kind of work doi DO NOT use reti	ne during most of wored)					
ygiene. ner than "natura t, the Medical E		8	ondary (0-12)		College (1-	401 5+)	Sea	mstres	S		Manuf	acti	ring	
d other event, Be C		17. Father's Name	(First, Middle,	Last)					18. Mother's Na	ame (First, Middle	Maiden Surnar	ne)		
Mental arked a atic ev		John T.	Lycet	tt					Mary	Scheel	er			
mar T	-	19a. Informant's N	ame/Relations	hip <i>(Typ</i> e.	Print)		19b. Maili	ng Address (Stre	et and Number or F	Rural Route Numb	er, City or Town,	State, Zij	o Code)	
Ithau 27 is rtrau		Marlene	Ludwi	ia /	Dauc	hter	8438	Arbut	us Road	, Pasad	ena, M	D 21	122	
Hea of he	$\vdash$	20a. Method of Disp					Place of Disp	osition (Name of matory or other p	(aca)	Date	20c. Location	City or T	own, State	
y or if		1 Burial 2 4 □ Donation			oval from S		-	ill Cer	4	17/07	P = 1 + -	mor	e, MD	
ortan Injur	-	21. Signature of				JCE							Home, PA	
any any once		1	14				1		iera Dr					
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											Approximate		
94		shock, or hea	art failure. List	only one	ralise on ea	ich line			and the same of th				Onset and Death	
nysician	Immediate Cause (Final disease or condition resulting in death)  a. Congestine Hert Fulling  Due to (or as a consequence of):  b. Hypertensive Atters sugart Conditions, if any, leading to immediate  Due to (or as a consequence of):											5 75		
Medical xaminer										. A.	-	1000		
95										<i>100</i> 07	_	')''		
in Sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
and Ftrar	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):													
cian Duria				l.			<b></b>							
d by the attending physicis letached for use as the bu				d										
ling F		IF FEMALE:		220	If you outo	ome pf pregr	ancy				00 d D	46 -1-15		
ttend or us		23b. Was deceder in the past 12		230	1 ☐Live bi	rth 2 ☐ Fe	tai death 3	⊒Ectopic pregna				ite of deliv onth	ery Day Year	
the a		1 ☐ Yes 2 I 9 ☐ Unknown	No		4∐Pregna 9☐Unkno	ant at time of wn	death 5	Other (specify,						
d by etach	1	Part II. Other signi		ane contri	buting to day	ath but not re	culting in the	inderlying cause	niven in Part I	23e Did	ohacco use con	tribute to	the cause of death?	
be d		Part II. Other signi		1	10 .		aditing in the t	andenying oddso	giver in t cit i.	10		-	bably 4 Unknown	
cate has been s page 2 should	3	160	have /	user	hrin	9								
as be 2 sh										24a. Was auto	an 24b.	Were aut prior to co	opsy findings available ompletion of cause of	
page										perfo 1□ Yes	2 No	death? 1 ☐ Yes	2 ANO	
ertifica ector, Be C		25. Was case reference examiner?	rred to medica	I					26. Place of D	eath (Check only	one)			
this certifical director,			10	Hos	pital: 1 ☐ In	npatient 2[	☐ ER/Outpatie	nt 3□ DOA	Other: 4 Nursing	Home 5□Resi	dence 6 □Ot	ner (Spec	ify)	
ter the neral		27. Manner of Dea 1 Watural			28a. Date o	f Injury n, Day Year)	28b. Time	of 28c. Ir	ijury at Vork?	28d. Describe	how injury occu	red		
ath. r: Af e fur		2 Accident	5 ☐ Pendin investi	gation	(	,, ,			☐ Yes 2 ☐ No					
by th		3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could determ		28e. Place o	of injury - At I	nome, farm, s	reet, factory, offi	e	28f. Location ( City or To	Street and Num wn, State)	ber or Rui	ral Route Number,	
rs after death.  a) Director: After led in by the funers  Certification:		_								<u> </u>				
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification: To Be Completed by Physician/Medical Examir		29a. Certifier (Check only one)	1 ☐ Certifyir 2 ☐ Medical	ng Physic Examine	ian: To the l r: On the ba and mann	best of my kr sis of examir er stated.	nowledge, dea nation and/or i	th occurred at the nvestigation, in n	e time, date and pla ny opinion, death od	ce, and due to the curred at the time	cause(s) and m , date and place	anner as , and due	stated. to the cause(s)	
ithin o the sample		29b. Signature and	d title of certifie	7				29c. Lice	ense number		29d. Date signe	ed (Month	, Day, Year)	
s ⊨ ō			///	. 6	/_		1.	1	130551	-	Konen	der 1	6,2007	
	-	00 Name 2 1 2 1 1	ross of some	who	oleted source	of death (Ita	m 23a) (Tuna	Print)	0,000				/	
		30. Name and add	ress of person	wilo com	nejed cause	or death (ite	iii zoaj (Type	, (11111)		1 11 -	1	2/7	70	
		1-11-	1. /1	PAL	1 11	D 70	1 12 000	+ /=: _+ /	ulnes 1	>1 Hursen	Ill 1	101		
State		31. Date filed (Mor	-	enni	32. Rg	strar's Sign	nature	Port A	propinion, death oceans number  D 30555	sa Hum	rus i	1/4/		

_			1 - For Amend Item 23a per dr	, <b>8873</b>		Death	entai Hyg	Reg. No. 200	7 36727
	Physici		1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	1 4	4c. County of Dea	
	Funanci		5833 PARK HEIGHTS AVENUE # 5. Social Security Number 6. Sex 7. Age (	302 (In yrs. last birth	BALTIMO	ORE If Under 24 Hrs.	8. Date of Birtl	N/ n 9. Bir	Athplace (State or Foreign
	Funeral Director		217-16-5815	-	rs. Months Days	Hours Min.	(Month, Day 09/05/1	v, Year)   C	POLAND
	yland now at		201	I0c. City, Town					10d. Inside City Limits
	ne Mar 8a-f sh otified	ector	MD N/A	B <b>A</b>	LTIMORE				1X Yes 2 No
	3a or 2	I Dire	10e. Street and Number 5833 PARK HEIGHTS AVENUE #	302	10f. Zip Code	215		10g. Citizen of What C	ountry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cub		cify Yes or No- Rican, etc.)		
N -0036	ours af	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give A 3 ☑ Widowed 4 □ Divorced Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify: WH	ITE
VIN 15-0	n 72 hours '"natural", edical Exa	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occup Give kind of work done life. DO NOT use retired	oation during most of workin	ng	16b. Kind of Business	/Industry
1E	d within giene.	Эт	Elementary/Secondary (0-12) College (1-4or 5+)		NAGER			GROCERY ST	ORE
LYN	i be filed ntal Hygi ed other event, ti	Be	17. Father's Name ( <i>First, Middle, Last</i> ) <b>SAMUEL</b>	GILDE	·N	18. Mother's Name FRIMA	(First, Middle,	,	IICK
EVELY!	2 should b and Ment is marked raumatic e	2	19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street		l Route Numbe		
ш	and 2 lealth a m 27 is		GARY J. LEVIN / SON		SNOWBERRY				
VID TO BI Baltimore	Pages 1 ent of H nt: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	BETH YE	Disposition (Name of crematory or other plan HUDA ANSHE		/2007	BALTIMORE.	
SAID   Baltin	permit. Pag Department Important: I any Injury o		21. Signature of F neral Service Litensee	KURLAND	22. Name and Addre	ess of Facility SO	L LEVIN	ISON & BROS	INC.
SA			23a. Part1. Enter the disease, or complications that caused th	e death. Do no					MD 21208 Approximate
	Physician		shock, or heart failure. List only one cause on each line.		ery Disease		, ,		Interval Between Onset and Death
9	/Medical Examiner		resulting in death)  Due to (or as a continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuous continuo			e Heart F	ailure		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Jonseque, ice of	). I	Jona Se			
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a disease)	2517.	e Hear	+ Fayle	THE.		
68760,	e be ex	cal E	d d	onsequence or,	<i>J.</i>				
	ertificat ing phy e as the	Medical	IF FEMALE:						
Ω Box	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the bunal-transit	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 2 State of the past 12 months?  4 Pregnant at tire of the past 12 months?	☐Fetal death	3 ☐ Ectopic pregnancy	у		23d. Date of de Month	elivery Day Year
P.0.	at the of	Physi	9 ☐ Unknown				00 011		
-	uires th signed d be de	þ	Part II. Other significant conditions contributing to death but	not resulting in t	the underlying cause giv	en in Part I.		bacco use contribute t 'es 2  No 3  F	. /
100 F	aw req is been 2 shoul	Completed			-		24a. Was a	an 24b. Were a	utopsy findings available completion of cause of
a R		Com					autop perfoi 1∐ Yes	med? ∣ death?	s 2 No
V.	/sician s certifi director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 □ ER/Outo	patient 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hor		ne) ence 6 □Other (Sp	noifu)
n or	ding Physician: The lav n. After this certificate has funeral director, page 2:	on: T	27. Mapper of Death 1 Natural 5 Pending (Month, Day Y	28b. Tir	me of 28c. Injur	y at 2		ow injury occurred	sony/
Division or Vital Records,	Attendideath.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury	- At home, farm	M 1 □ n, street, factory, office	Yes 2 □ No	8f. Location (S	treet and Number or F	iural Route Number,
ρj	ital or irs after ral Dire	Certi	Dullding, etc. (				City or Tow		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification is the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director, and the funeral director directors are the funeral director.	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of each of the basis of each only one)	ny knowledge, o xamination and/ d.	death occurred at the tile or investigation, in my o	me, date and place, a opinion, death occurr	and due to the ded at the time,	cause(s) and manner a date and place, and du	is stated. le to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	>	29c. Licens	e number	4	29d. Date signed (Mor.	th, Day, Year)
	(A) :		30. Name and address of person who completed cause of deal	th (Item 22a) /T	vpe Print)	13161		11/4/6	/ /
_	9	9	Detra Wer The Mer The	2434	W. Bel	vedere	HUR	Batto	THZIZIS
	Sta Registr		31. Date filed (Month, Day, Year)  NOV 1 6 2007	Signature	booth				th, Day, Year)
			LION TO FOOT MARRIED		The second secon				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 13, 2007 Littles Katharine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M & F Yrs. 01 Director 86 06 MD 213-20-3252 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show and 2 should be filed within 72 hours after death with the Marylai eaith and Mental Hygiene. m 27 is marked other than "natural"; or Items 23a or 28a-f show ner traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21216 1730 Moreland Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) na Social Security Adm Claims Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pauline Barron Thomas Hardy ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Robert G. Littles-Husband 20a. Method of Disposition 20b 1730 Moreland Ave, Baltimore, md 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 11/19/07 Owings Mills, Md 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pancreatic 8mo Cancer Due to (or as a consequence of): Hydronephrosis 3 mo Bilateral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 WK Pulmonary Edema attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown

**Physician** /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

ate has bade 2 s

Completed Be Certification: To .ne Hospital or Atts...thin 24 hours after death.

\* Funeral Director; After thir

\* "ad in by the funer?"

24a. Was an autopsy performed 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

5 Pending investigation

28a. Date of Injury (Month, Day Year) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Danna Disatatif, M.D.

Memorial Hospita

AT 2438946-H3 November 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doratotaj, M.D. Danna Union

31. Date filed (Month, Day, Year) NOV 1 6 2007

32. Registrar's Signature

To the Hospital within 24 hours a To the Funeral E

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Keith Lankford 9:39 A M Larry 11,2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 18,1953 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2□ F Maryland 54 218-62-1577 Feb. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XIYes 2 □ No Directo MD Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7109 Nimitz Drive Funeral 20747 USA 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black þ 3 Widowed 4 Divorced 1973 Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian D.C. Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry Lankford Vernetta Warlters ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lakeisha Lankford - Daughter 7109 Nimitz Dr., District Heights, MD 20747 20b. Place of Disposition (Name of cemejery, crematory or other place) Trinity United Meth. Church Cemetery 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) Nov. 19,2007 Salisbury. MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th St., NE, Washington, DC 20018 nome 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine and To the Hospital or Attending Physician: The law requires that the death certificate be exect Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ YPERTENSION 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate death? 1 ∐ Yes 2□ No 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2

Registrar

31. Date filed (Month, Day, Year) NOV 1 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D40324

NOVEMBER 12, 2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 7 0 0 7 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) NOVEMBER Day 11, 2007 7:20 P M **Physician** AGNES LUTRZYKOWSKI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GENESIS HERITAGE NURSING CENTER BALTIMORE DUNDALK 7. Age (In yrs. last birthday) 89 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 213-09-5300 1 □ M 2 X Director 06/15/1918 MD. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 🏋 ☐ No BALTIMORE MD. DUNDALK Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7232 GERMAN HILL ROAD 21222 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 6TH 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN RILEY ANNA KNIGHT ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARBARA REHAK/DAUGHTER 921 ESSEX SQ., BALTIMORE, MARYLAND 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2007 BALTIMORE, MARYLAND SACRED HEART OF JESUS 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist pnly one cause on each line. ULMONA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trai Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregrant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? signed þ 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b: Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 2 No 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA 1 🗌 Yes Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Funerai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29d. Date signed (Month, Day, Year) NOVEMBER 12,2007 wire Scripp red Course free ath Man 23 DT ype, Part 10 - A RITCHIE MOR Registrar's Signature 31. Date filed (Month, Day, Year) State 1 6 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend state of Maryland Bepartment of Health and Mental Hygiene

Certificate of Death

			a lot	partment of Mealth and Ment <i>ertificate of Death</i>	tal Hygier Reg. l	0000 04001							
×	Dharisi		Decedent's Name (First, Middle, Last)		ate of Death	3. Time of Death							
	Physici /Medic		Melvin Donald Lambdin		vember	12, 2007 1:15 A <sup>M</sup>							
X.	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
	Funeral	-	204 E. Joppa Road Apt 415  5. Social Security Aurager  6. Sex  7. Age (In yrs. last birthde	Towson  If Under 1 Year   If Under 24 Hrs.   8, Da	ate of Birth	Baltimore  9 Birthplace (State or Foreign							
	Director		217-20- <del>8354</del>   11XM 2LIF   81 Yrs	Months Days Hours Min. (A	Month, Day, Yes $\mathbf{ne}   9 ,   1$	9. Birthplace (State or Foreign Country) MD							
	land ow it		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits							
	Mary a-f shu	tor	MD Baltimore Towso	n		1 Yes 2 No							
	th the or 28, e not	Jirec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?							
	ath w	ral	204 E. Joppa Rd Apt 415	21286	US								
	ter de item	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	<ol> <li>Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican</li> </ol>	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.							
980	ours af	þ	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: White							
50	"natur	leted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of working a. DO NOT use retired)	16b.	. Kind of Business/Industry							
72	within iene. • than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Sal	es Management		Piano,Organ							
pu	be fill H d oth	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs		den Surname)							
ylaı		70	Martin Lambdin		Feuchte								
Mar				olling Address (Street and Number or Rural Rou									
ē,				04 E. Joppa Rd Apt 415 position (Name of rematory or other place)  Date		on, MD 21286  Location - City or Town, State							
<u>E</u>	Page nent o ant: If ury or		TX Durial 2 Dicientation 3 Dicentoval from State	Of Faith 11/16/07	7 В	altimore, MD							
Baltimore, Maryland 21215-0036	permit. Departr Importa any inju		21. Signature of Foneral Service Licensee	22. Name and Address of Facility Miller 6415 Belair Rd Balt	r-Dippe								
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			Approximate							
** Ve	Physician		Immediate Cause (Final disease or condition Character Cause (Final disease or condition Character Cause (Final disease or condition Character Cause (Final disease or condition Character Cause (Final disease or condition Character Cause (Final disease or condition Character Cause (Final disease or condition Character Characte										
	/Medical Examiner		resulting in death)  Due to or as a consequence of):	A da A Dag	7	276-1.3							
	÷ .	e.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	Arrery DISEAS	C	or years							
100	od ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  Cause (Disease or injury that initiated events  c.										
90	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):		·								
68760,	ificate be executed g physician and as the burial-transit	edical	d										
Box			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of delivery							
	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	Physician/M	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	B □Ectopic pregnancy 5 □ Other (specify)		Month Day Year							
P.0.	ires that the de signed by the a I be detached I		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tobacc	to use contribute to the cause of death?							
Vital Records,	quires t	d b	Diabetes Mellitus Type	Z		2 No 3 Probably 4 Unknown							
000	aw require is been sig	olete	Chronic Renal Faily	re 2	24a. Was an	24b. Were autopsy findings available							
ř	g Physician: The laver this certificate has stall director, page 2 and 100 and	Completed		1	autopsy performed □ Yes 2	prior to completion of cause of death? No 1 □ Yes 2 □ No							
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)								
	Phys r this or	은	1 ☐ Yes 2 No ☐ Hospittal: 1 ☐ Inpatient 2 ☐ ER/Outpat  27. Manner of Death 28a. Date of Injury 28b. Time	- I - I - I - I - I - I - I - I - I - I	Residence Describe how in								
<u>o</u>	nding ath. r: Afte e fune	ation	1√Natural 5 □ Pending (Month, Ďaý Year) Injur □ Accident investigation		DOGGNESS NOW III	ijury soouriou							
DIVISION OF	or Atte ter dea irecto	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		ocation (Street City or Town, St	and Number or Rural Route Number, ate)							
_	pital c		29a. Certifier 1 certifying Physician; To the best of my knowledge, de	oth cooursed at the time, date and place, and di	to the								
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	To the vithin To the comp	Me	29b. Signature are little of conflier	29c. License number	29d. [	Date signed (Month, Day, Year)							
1	, n		My wow wo	1)54124	1	1/14/0/							
	10		30. Napre and address of person who completed cause of death (Item 23a) (Typ	· _ ·		,							
in-	Stat	e	Dr. John Milto 7600 Osler Dr., S 31. Date filed (Month, Day, Year) 22. Registrar's Signature	uite ZIU									
	Registra	- 1	NOV 1 6 2007	All I									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 1040 AM 0054 NOVEMBER 13 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMOR If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign -46 12M 20F Months Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State County 10d. Inside City Limits Funeral Director 1 ☑Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Numbe 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 90 € 1 Yes, Give Year or Dates: / 98 € Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use refired) Elementary/Secondary (0-12) College (1-4or 5+) **F**ather Be 's Name (First, Middle, Last (First, Middle, Maiden Surname) 2 . Informant's Name/Relationship 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 ☐Removal from State permit. Page Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral/Service Licens 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE STROKE /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the attent detached for u 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>2</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performe 2 No 2□ No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA 1 Inpatient this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Md

DHMH 17 Rev 1/2001

AUSNUE BALTIMORE

EASTERN

s of person who completed cause of death (Item 23a) (Type, Print)

4940

gistrar's Signature

EMRICK

1ear

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hn Henry Morris	State 1- For State Registrar	e of Maryland /	Departme Certifica			and M	lental H		200	7 3673	
Physician/ edical Examiner	Decedent's Name (First, Middle,La	Henry	Мо	orris	1			2. Date of Deat Month November	h	3. Time of Death 1622 hrs	
	4a. Facility Name (if not institution, g University Hospital	ive street and number)			. City, Town		tion of Deat		4c. County of Death	h	
Funeral Director			(In yrs. last birth	day) Yrs.	If Under 1 Months		Under 24Hr Hours Mir	_	th(MM/DD/YYYY) 9. Bit -1965 Foreign	rthplace (State or gn Md .	
۸	Usual Residence of Decedent  10a. State 10b. County		I0c. City, Town o	- Looptio						10d. Inside City Limits	
now an	10a. State 10b. County NA			timor						1 X Yes 2 No	
the Maryland a or 28a-f sh tifted at once	10e. Street and Number			T	10f. Zip Coo			10	0g. Citizen of What Cou	intry?	
ith the last or notified	1428 Presstman			10.11/		.217	04-1-046	16 9	o- 14. Race - American Indian, Black,		
cer death with the Maryland , or items 23a or 28a-f show any r must be notified at once. Funeral Director	11. Marital Status 1 XNever Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent E Armed Forces? 1 Yes 2 dd If Yes, Give Year	X No	If Yes		uban, Mex	kican, Puert	Specify Yes or No- o Rican, etc.)	14. Race - Amel White, etc.		
ours after attural tramine	45 December 5 december 10 control	or Dates:		ecedent's	Usual Occ	upation (0	Give kind of		16b. Kind of Business.		
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Elementary/Secondary (0-12) 10th grade	College (1-4 or 5-	+) d	•	t of working	3	NOT use re	,	<u> </u>	els & Resort	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medica</u> To Be Comple	John	н.			s, Jr.	.	Mar	У	Maiden Surname) Ba		
Should and Me 7 is ma matic ex	19a. Informant's Name/Relationship Mary Morris	(Type, Print)  Mother	19b	•	,				nber, City or Town, Statemore, Md.	e, Zip Code) 21217	
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is nijury or other traumati	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - Cit								20c. Location - City o	r Town, State	
Pages nent of ant: H	1 X Burial 2 Cremation 3 4 Qonation 5 Other Specia			•	. Pk.		11	-17-07	Randalls	town, Md.	
Balti permit. Departu Import	21. Signeture of Funeral Service Lice	Philter	m		me and Add			March F. e., Balt	H. East imore, Md.	21202	
Physician /Medical	23. Part I. Enter the disease, or confailure. List only one cause on	each line.		enter the	mode of d	/ing, such	as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
-xaminer	Imm diate Cause (Final disease or ondition resulting in death)	a. Gunshot wound  Due to (or as a conse								Death	
er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):										
ted Innsit Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):								
0, e be executed ysician and burial - transit	UNPENDED	d									
60, ate be ex hysician e burial	IF FEMALE:	23c. If yes, outcom	e of pregnancy						23d. Date of delive	ry	
). Box 68760, the death certificate be executed by the attending physician and exched for use as the burial - transi-Physician/Medical E.	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at t	ime of death 5		l death er <i>(Specify)</i>		ctopic pregi	nancy	Month	Day Year	
P.O. Be sthat the degree by the edetached for by Phy			but not resulting	in the un	derlying car	use given	in Part I.		obacco use contribute to		
ls, P.( quires tha en signed ald be det	ļ <del></del>							1 Ye:		obably 4 Unknown	
Division of Vital Records, P.O. B at or Attending Physician: The law requires that the d rash.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached ertification: To Be Completed by Phypritication: To Be Completed by Phyprograms.								autor perfo 11 <b>✓</b> Yes	prior to death?	completion of cause of	
Vital   ysician: his certifi director,	25. Was case referred to medical examiner?	Hospital: 1 / Inpatier	+ 2 EP/O	tpatient		Otho	eath (Chec	k only one) sing Home 5	Residence 6 Oth	Δr·	
n of Viture of the control of the co	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Deading	28a. Date of Injur	v 28b. 1	ime of Inj	ury 28c	. Injury at	Work?		how injury occurred		
ivisior or Attend after death Director: I in by the tificatio	2 Accident Investiga	ation 28e Place of Init				Yes				Rural Route Number, City	
Division of oppital or Attending I hours after death.  I meral Director: After y filled in by the function: I continue to the function of the	3 Suicide 6 Could no determin	ot be						or Town, S Baker St. and	State) I N. Carey St., Baltin	nore, Md	
To the Hospital within 24 hours. To the Funeral completely filled	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of my er:On the basis of exam	knowledge, dea nination and/or in	th occurre	ed at the tim on, in my op	ne, date ar inion, dea	nd place, ar ath occurred	nd due to the caus at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)	
N S T S S	29b. Signature and title of certifier	and manner stated.				cense nu			29d. Date signed (M		
	Jashe	Jee / A	ub		c	C.M.E			November 13, 2	2007 	
10	30. Name and address of person wh Tasha Greenberg MD.	o completed cause of de Assistant Medica		111 F	enn Stre	et, Bal	timore, N	ID 21201			
State Registra		32. Registrar	's Signature	and.	E						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ÖRIGINAL

amend item 19h per Mary 1873 Debarren of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician 0: 30 A. M Middleton NOVEMBER 13 2007 Josephine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** NA BALTIMORE SAMAR 17 Am HUSPITAR GODD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 □ M 2 🕱 F 7.3 248-48-6398 S.C. 6-20-1934 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No NA Baltimore Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21213 USA 4009 Shannon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Black Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) J.H.H. <u> Housekeeping</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Small Jane Middleton Marv Waiter Jessie ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4009 Shannon Str., Baltimore, Md. 21213 21206 19a. Informant's Name/Relationship (Type. Print) 4009 Shannon Sr., Baltimore, Md. Pages 1 and 2 × trment of Health a Tony Hill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1√ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Important: If it any injury or c 11-17-07 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East ladio 21202 1101 E. North Ave., Baltimore, Md. Ø wans 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician RECURRENT ADBNO CARCINGMA 6 min) ERITONER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine for use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. a I Inknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death | Check only one To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation spital or Attendi ours after death. neral Director: A death. 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING MEDICAL DOO 62239 NOUGHBER 13 2007 GOOD SAMARITANS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAING 00 Day Year) 32. Registrar's Signature 31. Date filed (Month, State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year /Medical Norma H. Moessinger 2007 12:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS Frostburg Nursing & Rehab Ctr Frostburg MD If Under 1 Year | # Onder 24 Hrs. <u>Allegany</u> 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 TYF 216-03-8382 **Director** May 25, 1917 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits Medical Examiner must be notified at Director Allegany 1 ☐ Yes 2 XNo Maryland Frostburg 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 48 Tarn Terrace 21532 Funeral USA 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛛 No þ Specify: 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'any injury or other traumatic event; the Me ones. Elementary/Secondary (0-12) College (1-4or 5+) 12 years Bank Teller Bank 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Surname) Frederick Randles Mary Weiberg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Mc Cadden Daughter 900 E. Joppa Road, Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) November Moreland Memorial Baltimore, Maryland 16, 2007 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part1. Enter the disease, shock, or heart failure. L e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heard 6 months /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): physician Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4□Pregnant at time of death Month Day Year 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ advanced Demento 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No page 2 autonsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation after death 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Climedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: completely filled in by the funeral within 24 hours a To the Funeral I the

State

29b. Signature and title of certifier

Registrar

worseth this

29c. License number 29d. Date signed (Month, Day, Year)

NOV 13, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

cumberland MD 21502 BISHOP WALSH RD SHIN 925 WONSOCK 31. Date filed (Month, Day, Year) NOV 1 6 2007

000 55 325

32. Registrar's Signature

	riease Type of Thirt in Didok indelible lik. Litatie All copies Are Le
For	State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	arylanu / L	_	tificate of		and Mei		eg. No.	)07	3673	36
v.	Physicia	20	1. Decedent's Name (First, Middle, La	st)						Date of Dear Month		Year	3. Time of De	
	/Medic		Dorothy		M	art				Month ovembe			6:13	P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or Chevy Cl		or Death			nty of Death gomery		
	Funcion		Manor Care  5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth			place (State or Fo	oreign
	Funeral Director		232-40-4489 Usual Residence of Decedent	I□M 2 <b>K</b> 1F	78	Yrs.	Months Days	Hours	Min. F	Date of Birth (Month, Day eb. 17	192	9 Tam	s, WV	
	ow ow		10a. State 10b. County		10c. City, Town	n or Lo	cation						10d. Inside City L	imits.
	Mary a-f sh	tor	WV Raleigh	ı	Beckle	∍у							1 <b>∏</b> Yes 2[	□No
	th the	)ire	10e. Street and Number				10f. Zip Code			1	10g. Citizen of What Country?			
	ath wi	Funeral Director	102 Terrell Stree			1.0.1	25801		. 0 (0	No. of No.	U.S.		ican Indian	
	er de items	ine	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💢 !		13. \	Was Decedent of H f Yes, specify Cuba	an, Mexicar	gin? (Specify n, Puerto Ric	an, etc.)	or No- c.) 14. Race - American Indian, Black, White, etc.			
2	urs aft	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1∐Yes 2⊠No	Specify:			Specify: Black			
5	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. The salth and Mental Hygiene. The marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during mos	t of working		16b. Kind o	f Business/Ir	ndustry	
7	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5	i+)			d)		,	Healtl	Caro		
7	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Me		17. Father's Name (First, Middle, Last	4		P	lurse	18. Mothe	er's Name (F	irst, Middle, i				
	d be fantal heed of	o Be	John Caldwell	,			1	Vir	ginia	Lyles		,		
<u> </u>	should not mark	၉	19a. Informant's Name/Relationship (	Type. Print)	19b	. Mailir	ng Address (Street				r, City or To	vn, State, Zi	ip Code)	
Ä	alth a alth a 27 is		Lawanda Martin-Do	ouglas (Day	ighter)	4	240 Lave	nder	La., E	Bowie,	MD 20	720		
ָט כ	of He fitem		20a. Method of Disposition 1 X Buria 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemete	f Dispo ry, crer	sition (Name of natory or other plac	ce)	Date	•	20c. Location	on - City or T	Town, State	
É	Pag ment ant: i		4 □ Denation 5 □ Other (Specific	fy)	Greenv		l Mem. Pa				Beckl	ey, W	V	
5	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trai		21. Signature of Funeral Service Lice	risee)	-		1 LChie					25001	ı	
	40260		23a. Part1. Enter the disease, or corr shock, or heart failure. List only	Missions that caused	the death. Do		48 S. Fay					23001	Approximate Interval Between	
	Dhysisian		Immediate Cause (Final										Onset and Dea	eth
	Physician /Medical		disease or condition resulting in death)	a. Metastat Due to (or as	a consequence		Primary (	Jn Know	vn					
	Examiner		Conventially list conditions	b Congesti	ve Hear	t F	ailure							
	₽W Ħ	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):								
	and Lirans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						$\rightarrow$					
5	rtificate be executed ng physician and as the burial-transit	calE	Severe Anemia											
2	tificate ig phy as the	ledical												
Š	ath cer tendir or use	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregnanc	у			23d.	Date of deli	very Day Yea	ar
5	the dea y the at ched fo	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of death	5 L	Other (specify) _							
	s that ned by e deta	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the u	nderlying cause giv	en in Part I		23e. Did to	bacco use o	ontribute to	the cause of dea	th?
3	equire en sig vuld b	ed b	<u>Dementia</u>							1 □ Y	es 2□N	o 3∏Pro	obably 4 🕅 Unk	nown
ב כ	law re as bed 2 sho	Completed								24a. Was a	sy	lb. Were aut	topsy findings ava	uilable se of
	The ate his page	Com								perfor 1□ Yes	med? 2M No	death? 1 ☐ Yes	2 □ No	
211	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			oth			check only or				
5	Phys r this ral dir	. To	1 ☐ Yes 2 🔯 No  27. Manner of Death	28a. Date of Inju	ry 28b.	Time o	IL SU DOA	4 E NU		5 ☐ Resid			cify)	
5	nding th. : Afte s fune	tion	1 Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year)	Injury		rƙ? ∣Yes 2 🔲	No					
2	Atter er dea rector by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		28f.	Location (S City or Tow	Street and No	ımber or Ru	ral Route Numbe	r,
5	ital or irs afte rai Dii led in	Cerl												
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 but safe for the second by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier  (Check only one)  1	hysician: To the best miner: On the basis o and manner st	f examination ar	e, deat nd/or in	h occurred at the ti	me, date ar opinion, dea	nd place, and ath occurred	at the time,	date and pla	ce, and due	to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier	1/10-	2 6	1	29c. Licens	se number		2	29d. Date si	gned (Month	n, Day, Year)	
	./		) cui	von		1/	D202	74		N	lovemb	er 13	, 2007	
	5		30. Name and address of person who				Print) Blvd.,	Rethe	sda. M	D 2081	7			
	Sta	ate	Kirti Vohra, M.D. 31. Date filed (Month, Day, Year)	32° Begistr	ar's Signature			JU 01101	July II		. ,			
	Registr		NOV 1 6 2	007 2000	ar o dignature	A. M.	and a second							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Stephen Joseph Maltese, Sr. 4:30P M November 12, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Levindale Geriatric Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours 220-12-9288 Director 80 March 21, 1927 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Waveland Road 21228 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∏ Yes 2 □ No If Yes, Give Year or Dates: "natural", or it 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglene Important: If item 27 is marked other the any Injury or other traumatic event, the once. 5+ School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis Maltese Carrie Welzenbach 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Marie Maltese Wife 319 Waveland Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Redeemer 11/19/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of uneral Service Licenses 1630 Edmondson Avenue; Catonsville 21228 23a. Part1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Chronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Live birth in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4. Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Zong 24a. Was an autopsy 2 No 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: Certification: To 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No illed in by the fr 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0065918 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Avenue, Baltic 2434 V 32. Reginar's Signature Sein,  $\mathfrak{m}\mathfrak{D}$ 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland Amend Item 24a, 25, 26, 23e p	Department of Health and Certificate of Death	Mental Hygie <b>Ihb</b> Reg.	ne Noon
	Di salah		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	Physici /Medi		James Mumford		October	30 2007 4 pm M
	Examir	ner	4a. Facility Name (If not institution, give street and number)  6000 D SAMARITAN HOSPITAL	4b. City, Town, or Location of Deat BALTIMORC	h	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 7. Åge (In yrs. last 69	birthday) If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct 28, 1	
	w		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location		10d. Inside City Limits
	f sho	ō	100	altimore		1√2 Yes 2 □ No
	the 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	3a or	D	115 E. Melrose Avenue	21212		TICA
	deatl	Funeral	11. Marital Status unk 12. Was Decedent Ever in U.S. Armed Forces?	nk 13. Was Decedent of Hispanic Origin? (S	specify Yes or No-	USA 14. Race - American Indian,
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	to Mican, etc.)	Black, White, etc.  Specify: black
2-0	72 ho natur lical	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of wo	rking unk 16th	o. Kind of Business/Industry unk
21	ithin ne.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
121	filed w Hygier ther th		unk unk	1 19 Mothor's No.	mo (First Middle Mai	don Curnama)
and	lbe fi	Be	17. Father's Name (First, Middle, Last)	unk 18. Mother's Nai	ne (First, Middle, Maio	unk unk
Maryland	2 should be and Mental Is marked o	욘	19a. Informant's Name/Relationship (Type. Print)	9b. Mailing Address (Street and Number or R	ural Route Number Ci	ity or Town State Zin Code)
Ma	d2s than t7 Is r traur		Good Samaritan Hospital	5601 Loch Raven Blvd		
	1 and 2 Health tem 27 I		20a. Method of Disposition 20b. Place	of Disposition (Name of		, MD 21239 c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state	etery, crematory or other place)		
Ħ	artme			22. Name and Address of Facility		
Ba	permit Depar Impor any Ir once.		21. Signature of Fungral Service Licensee Ronald S. Wade Director	State Anatomy Boar		
	100		23a. Party. Enter the disease, or complications that caused the death.	o not enter the mode of dying, such as cardia	O1 c or respiratory arrest,	Approximate
	Physician /Medical Examiner		shock or heart failure. List only one cause on each line. Immediate Cause (Final	le Muncard	16/ 7	Approximate interval Setween Once and Death
			disease or condition resulting in death)  a. Due to (or as a consequent	ce of):		
			Conventable tite and divine			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	se ofy:		
	ecute nd trans	Examiner				
00	e exe	Ě	Due to (or as a consequent	ce of):		
8760,	ate b	dical	d			
9	iertific ding p	Me	IF FEMALE:	<del></del>		V
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy	ath 3 ☐Ectopic pregnancy		23d. Date of delivery  Month Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 5 ☐ Other (specify)	-	
P.0	hat the death certificate be executed by the attending physician and letached for use as the buriat-transit		Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	uires sign Id be	d by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w requir been s should	Completed			24a. Was an	24b. Were autopsy findings available
Re	he lav e has ge 2	ם	-		autopsy performed	prior to completion of cause of death?
Vital		ပ္ပ	25. Was case referred to medical	26 Place of De	1□ Yes 2 <b>½</b> ath <i>(Check only one)</i>	No 1 ∐Yes 2 XNo
>	Physician: The this certificate har all director, page	To B	examiner? Hospital:	Other:	-	e 6 □Other (Specify)
10	<b>5</b> = <b>3</b>		27. Manner of Death 28a. Date of Injury 28	b. Time of 28c. Injury at Work?	28d. Describe how i	
Division	Attending r death. ector: After by the funer	atio	1 ☐ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	M 1 Yes 2 No		
Vis	er der	iific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ö	tal or	Certification:			1,	
	To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	1 — 1	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowle careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician: To the basis of examination careful physician careful physician careful physician careful physician careful physician careful physician careful physician careful physician careful physician careful physician careful physi	dge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the caus urred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
	withir To the Comp	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
			Turne Com	1 (885000)		crober 30, 2001
•			30. Name and address of person who completed cause of death (Item 23) Terrance L. Balcern D	a) (Type, Print) San witan	Hospita	1 Baltone MD
	Sta Registi	ate rar	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23)  Terrove L. Ballcern D  31. Date filed (Month, Day, Year)  NOV 1 5 2007	Sparte		

3

Tracy Morgan 07-08798	アタートゥック Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
UNK UNK	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2007 3573
Physician Medical Examine	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year
C	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  1217 Linworth Avenue Apt. 1A  Baltimore
Funeral	5. Social Security Number  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYY)  One of Birth(MM/DD/YYYYY)   One of Birth(MM/DD/YYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYY
Director	Usual Residence of Decedent
Maryland 28a-f show any d at once.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 \text{ Yes } 2 \square No
Fig. 19	
leath with the latters 23a or oust be notified	11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
ral", or i	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: Specify:
72 hours al Exam	, 1 15. Decedent's Education (Specify only highest grade completed) 116a. Decedent's Usual Occupation (Give kind of work done 116b. Kind of Business/Industry
-0036  4 within 72 hourspiece.  There than "nate of Medical Example for Committee of Committee o	17. Father's Name (First, Middle, Last)  Clerical Ketai  18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 3 marked other than marked other than fice event, the Medica	Henry B. Manns, Sr. Violet A. Allie
MD 2 d 2 should the and M n 27 is m n 27 is m	19a. Informall's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Aumber, City or Town, State, Zip Code)  Denise E. Alvarez (Sister) 16008 NW 66th Terrace, Tamarac, FT 3332]
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiere Important: If tiem 27 is marked other than injury or other traumatic event, the Medical To Re Comple	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,  1 Burial 2 Cremation 3 Removal from State  20c. Location - City or Town, State
Baltimore, permit. Pages I ar Department of the Important: If the injury or other tr	4 Donation 5 Other Specify: Signature of Funeral Service Licensee  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Vaughn C. Greene Funeral Services
m ឱ្ង ≝ ፪ Physician	Vaughn C. Greene (per DVR)  5151 Baltimore National Pike Baltimore, MD 21229  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Cocaine intoxication Between Onset and Death
	or condition resulting in death)  Due to (or as a consequence of):  Seguentially list conditions,  b.
led nsit	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated
	X UNPENDED #23a,PII.27,28a-f., perME,8873, 11/21/07 TT #21.22, perFH.08/3, 11/16/07 TT
Box 68760 e death certificate b the attending physical for use as the but we for use and the but we for use and the but the bu	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 One of Death (Security) 23d. Date of delivery Month Day Year
Box e death of the atter	1 Yes 2 No 9 V Unknown 9 Unknown
P.O. es that the igned by or detach	1 Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funcaral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burindirical Certification: To Be Commission by Physician/Med	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Recci The la fficate ha	performed?  1 Ves 2 No 1 Ves 2 No
Vital hysician hysician this certical	Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene
on of \nderstand of Of \nderstand of Of Of Of Of Of Of Of Of Of Of Of Of Of	
Division or spiral or Attending nours after near Director: After filled in by the fune.	2 Accident 3 Suicide 5 Pending Investigation 6 X Could not be 6 X Could not be 7 Pending Investigation 8 Pending Investigation 9 Pending Investigation
Divisior  To the Hospital or Attend within 24 hours after death for the Funeral Director: completely filled in by the lendical Certification	
To the How within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  November 13, 2007
A	30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Stat	31. Date filed (Month, Day, Year)
Registra  DHMH 17 Rev 1/2001	
OCME 2006	OCME ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend. item. 8 per fb 9873 11-20-07 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year NOVEMBER 10 2007 16:03 M APRIL MATTOCKS 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Death SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Oays Hours Min. July 150 Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1□M X □ F 216 82 1241  $\frac{7}{1973}$  MD. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE X□Yes 2□No 10f. Zip Code 21202 10e. Street and Number 10g. Citizen of What Country? 814 WEBB COURT USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, GiveX Year or Dates: XX ever Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth RESTAURANT PREP COOK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MAURICE JOHNSON INEZ MATTOCKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONICA M.SMITH (sister) 814 WEBB COURT BALTIMORE, MD. 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State \*\*Burial 2 Cremation 3 Removal from State Trinity Cemetery Nov.16,2007 Balto.MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22 Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO.MD. 21213 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of): BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). ISCHE MIC Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SLE 1 Yes 2 No 3 Probably 4 Unknown hemodialysis ESRD On 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Alatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES-000 Nivember 10,200

29d. Date signed (Month, Day, Year)

Examiner P.O. of Vital Records, Division

burial-transit ed by the attending physicien detached for use as the buria signed by t peeu certificete has funeral director. this After death. el or Attend s efter death I Director: A d in by the fi To the Hospitel or Atterwithin 24 hours efter des To the Funeral Director completely filled in by the

**Physician** 

/Medical

Examiner

MD.

Direct

þ

Completed

Be

Examiner

Physician/Medical

þ

Completed

Be

٩

Certification:

4 Homicide

29b. Signature and title of certifier

TA2EEN

29a. Certifier

**Funeral** 

Director

item 27 is marked other then "naturel", or items 23a or 28e-f ehow other treumatic event, the Medical Examinar must be notified at

s 1 and 2 should be filed within 72 hours if Heelth and Menta! Hygiene.

permit. Pages 1
Department of H
Important: If its
any Injury or ot

Physician /Medical

pue

Maryland 21215-0036

Baltimore,

えるも

State Registrar 31. Date filed (Month, Day, Year) NOV 1 6

REHMAN, MD SINA HOSPITAL OF BALTIMURE 32. Registrar's Signature and the

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Tertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On ine pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend #6, perFH, 0873, 11/21/07 TT Certificate of Death

Reg. No. Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SARAH NOVEMBER 13 MACKLIN 2007 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BRIGHTWOOD LUTHERVILLE If Under 1 Year | If Under 24 Hrs. BALTIMORE Birthplace (State or Foreign Country) PA Social Security Number 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Months Hours Min. Director 76 220-24-7180 09/28/1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f sh Director 1 ☐Yes 2 No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 14 ROMNEY COURT Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or item edical Examiner n 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give ☐ No Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: WHITE 3 M Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than, BI'S Elementary/Secondary (0-12) College (1-4or 5+) 6 SALES <del>BG'S</del> WHOLESALE or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN KLINGER 2 GERALDINE NIGHTHART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIM FRINER / DAUGHTER 14 ROMNEY COURT - OWINGS MILLS, MD. 21117 20b. Place of Disposition (Name of PETACH TIKVAH 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11/15/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208
Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NNG EZ with Metastases **Physician** cal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of) the attending physician Physician/Medical Box ( 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 I Inknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe Yes 2 or Vital 1∐ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier ndol D25643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6365N. Charles St Sute 204/ 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

0

		Plea	ase Type or Prir							egible.	
		For State	State of Ma	aryland		artment of H		lental Hy	giene		
		1 State Registrar  1. Decedent's Name (First, Midd	fla / act)		Cer	rtificate of l	Death	2. Date of De	Reg. No.	2007	33 5 7 1 2
Physicia		Marilyn	S. Palo	0				Novemb		4 200;	7 08:40 PM
/ /Medic Examin		4a. Facility Name (If not institution	on, give street and number)			4b. City, Town, or	Location of Death		4c. 0	County of Deat	th
		Kris Leigh Ass					na Park	T		Anne Ar	
Funeral Director		5. Social Security Number 213-30-0430	6. Sex 7. Ag	e (In yrs. las 7.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	32 9. Bin	thplace (State or Foreign buntry)  MD
70		Usual Residence of Decedent				<u> </u>		IAUY.	13 13	32	
arylan show d at	ř	10a. State 10b. County		10c. City,	Town or Lo						10d. Inside Cify Limits 1 ☐ Yes 2 ☑ No
the M 28a-f notifle	Director	Maryland Anne	e Arundel			10f. Zip Code	adena		10g. Citiz	en of What Co	
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	al Di	1847 Poplar R	idge Road				21122			US.	-
ems 2	Funeral	11. Marital Status	12. Was Decedent   Armed Forces?		13. \	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 1	4. Race - Ame Black, Whit	
s afte	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes, Give	No		1□Yes 2风No	Specify:			Specify:	Mhite
2 hour	ted t	15. Decede	ent's Education		16a. Deced	dent's Usual Occup	ation		16b. Kin	d of Business	/Industry
thin 7, ie. ian "n	nple	Elementary/Secondary (0-12)	est grade completed)  College (1-4or 5	5+)	life. L	kind of work done of	during most of work f)	ang		da + + a	
lled willed will her there there there there there there there there there there is a second to the there is a second tof	Be Completed	17. Father's Name (First, Middle				Teacher	18. Mother's Nam	e (First Middle		ducatio	)[[
d be f ental F ced ot	To Be	Harold E.	Slanker				Evva	Johns		Jamamay	
shoul and Ma s marl	۲	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailin	ng Address (Street	and Number or Ru	ral Route Numi	ber, City or	Town, State,	Zip Code)
and 2 ealth a n 27 is		Brenda Palo	(daughter)			Tall Timb					
ges 1 t of Hi if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 □Removal from State			sition (Name of matory or other plac	11000	Date 15		cation - City or	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Martal Hygiene. Important: If Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 □ Donation 5 □ Other ( 21. Signature of Funeral Se vio		Metr		ematory Ir 2. Name and Addres	10	007 Stallin	Balt	<u>imore,</u>	Maryland
Depart Impo any		I Hild	Jan J.			3111 Mour	ntain Roa	d, Pasa	idena,	MD 21	Home, PA 122
The A		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused st only one cause on each lin	the death.	Do not ent			or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_a Auto	munic	me	hepa	titis				Onset and Death
/Medical Examiner		resulting in deathy	Due to (or as	a conseque	ence of):	กัง					
· ·	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseque	ence of):						
e executed	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C								
be execut ician and burial-tran		resulting in death, East	Due to (or as	a conseque	ence or):						
eath certificate be attending physici for use as the bu	edic		d								
th cert ending	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth	pf pregnand	cy death 3⊡	Ectopic pregnancy	,		2	3d. Date of de	
Attending Physician: The law requires that the death certificate b redsth.  ector: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the b	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown			Other (specify)				Month	Day Year
w requires that the de been signed by the should be detached		Part II. Other significant condit	tions contributing to death b	ut not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	o the cause of death?
quires in sign	ed by							1 🗆	Yes 2	No 3□P	robably 4 Unknown
e law re has bee je 2 sho	Completed							24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
: The cate h	Com							per 1□ Yes	formed? 2 ZNNo	death? 1 ☐ Yes	. /
Physician: The la rr this certificate has aral director, page 2	Be	25. Was case referred to medic examiner?	Hospital:	005	R/Outpatier	ot 3D DOA Oth	er:	١.			
g Physer this eral di	n: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie	ıry 2	28b. Time o	" O DON	4 LI Nursing F	28d. Describe			есігу)
ending F pr: After he funer	atio	Z Accident	tigation		Injury	M 1 🗆	Yes 2 □ No				
or Att fiter de Direct	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined   200. Place of Inj	ury - At horr ic. <i>(Specify)</i>	ne, farm, str	reet, factory, office			(Street and own, State)		ural Route Number,
To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: A completely filled in by the fur			ring Physician: To the best								
the Ho in 24 h the Fu ipletely	Medical	one)	al Examiner: On the basis o and manner st		on and/or in			rred at the time			
Vith Vith Con To t	Z	29b. Signature and title of certifi	ier			29c. Licens				e signed (Mon	
7		30. Name and address of perso	on who completed cause of a	leath (Itom 9	23a) (Type	Print)	7.5		Nove	M W	17, 2001
10		Vnaemcka	Danielu An	W 11	HII M	ladison fo	whe Drive	416	Sten	Bruie	15, 2007 My 21061
Sta		31. Date filed (Month, Day, Yea	AV.	rar's Signatu	ire A	K)					
Registr	ar	NOV 1 6	LUUI ANDRES	1.1	July 1						

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

5:26 Novembe 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) 08/16/1955 If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, NY Country) **Funeral** Days Hours Min 1 M 2 ☐ F 52 120-40-9609 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or tlems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🗷 No Director Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20879-19040 Sedley Tarrace Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Repro Graphics Technol (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Lead Production Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary M Prior Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Mays Ave Hornell, NY 14843-Deloris N. Perkins/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov 12 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc.2007 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility remation Services 21. Signature of Funeral Service Licensee M0038Z Stiplu & Lohn Silver Spring, Maryland 20910-933 Gist Ave. Approximate Interval Bety Onset and D 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician neumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed for use as the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown as been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 2**0** No 1 TYes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 MoNo 1 Pinpatient 2 ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 2 No &□ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVILLE CHANALES 15225

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Bay, Year)

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State

Registrar

DEALE

OSLER DRIVE TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 1 6 2007

32. Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

**Funeral** 

Director

Physician /Medical Examiner

as the burial-transi

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar 20

Division or Vital Records, P.O. Box 68760,

- 1		Usual Hesidence of Decedent										
6	,	10a. State 10b. Counfy	10c. City,	Town or Loc	eation					10d. Inside City Limits		
	형	Maryland Montgomery	Sandy	7 Spri	ng					1 ☐ Yes 2 X No		
	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of What (	Country?		
5	9	18131 Slade School Road			20860			11	nited Sta	ites		
	Funeral	11. Manital Status 12. Was Decedent								nerican Indian,		
	ᆵ	1 Never Married 2 Married 1 Yes 2								nite, etc.		
	ğ	3 ⚠ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No Specify: Specify:						White		
	ted	15. Decedent's Education		16a. Deced	ent's Usual Occu	pation		1	6b. Kind of Busines	s/Industry		
	윤	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+)	life. D	kind of work done O NOT use retire	auring most ( ed)	ot working	- 4				
	Completed	12		Computer Operator Telecommu						ications		
	Be (	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)								
	2	Fletcher Hicks				Carli	e Smi	Lth				
		19a. Informant's Name/Relationship (Type. Print)	Ĭ	19b. Mailin	g Address (Stree	and Number	or Rural R	loute Number,	City or Town, State	, Zip Code)		
		Lyle B. Padgett / Son		6301 Grafton Farm Drive, Laytonsville,						MD 20882		
		20a. Method of Disposition	20b. Pla		sition (Name of natory or other pla		Date		0c. Location - City of			
		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	7		norial Par	1	nz. 17.	2007 R	nckville.	Maryland		
60	Ì	21. Signature of Funeral Service License	120210									
once	6 /	M00896 Robert A. Pumphrey Funeral Home/Rock 300 W. Montgomery Ave., Rockville, N										
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near tailure. List only one cause on each line.  Approximate Interval Between Onset and Death										
an	1	Immediate Cause (Final disease or condition Lymphon	ma							Unset and Death		
al		resulting in death)  Due to (or as	s a conseque	nce of):								
er		Sequentially list conditions. b										
	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course (Cleans or Injury)	s a conseque	nce of):								
	Examiner	that initiated events c.								2		
		Due to (or as	s a conseque	nce of):								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 1   Dither significant contribution to death but not resulting in the past 12 months? 1   Unknown   23c. If yes, outcome pf pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Dither significant contribution to death but not resulting in the underlying region in Review 200 picks in Review 200											
	Me	IF FEMALE: 23c. If yes, outcome pf pregnancy										
	ian/	in the past 12 months?	2 Fetal c	Il death 3 Ectopic pregnancy					23d. Date of d	lelivery Dav Year		
	Sic	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant a 9 ☐ Unknown	at time of dea							Day Teal		
	된	Part II. Other significant conditions contributing to death b	hut mat vanult	: :-	dadidaa aa	and in Death	- 1	00+ Did +-b-				
		Pericardial Mass	out not result	ing in the un	denying cause gr	ven in Parti.				to the cause of death?		
	Completed by	reficatoral mass					— ↓	1 ∐ Yes	2 No 3	Probably 4X Unknown		
	e l			10				24a. Was an autopsy	24b. Were	autopsy findings available completion of cause of		
	PO.							perform 1 Yes 2	ed?   death?	es 2 No		
	Be	25. Was case referred to medical examiner?				26. Place o	of Death (C	heck only one				
	6		ient 2 El	R/Outpatient	3□ DOA Oti	ner: 4🔀 Nurs	sing Home	5 ☐ Residen	ice 6 □Other (Sp	pecify)		
	Ë	27. Manner of Death 1 Natural 5 Pending (Month, Date of Inju (Month, Da	ury 2 ay Year)	8b. Time of Injury	28c. Inju Wo	ry at rk?	28d	. Describe hov	injury occurred			
	ig	2 Accident investigation				Yes 2 □ N	0					
	<u>≗</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of inj building, et	jury - At hom tc. <i>(Specify)</i>	e, farm, stre	et, factory, office	-	28f.	Location (Stree	eet and Number or I State)	Rural Route Number,		
	Če	l l										
	Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examinatio	edge, death on and/or inv	occurred at the t estigation, in my	ime, date and opinion, death	l place, and h occurred	due to the cau at the time, da	use(s) and manner at te and place, and d	as stated. ue to the cause(s)		
	ž	29b. Signature and title of certifier			29c. Licens	se number		29	d. Date signed (Mo	nth, Day, Year)		
	D39793							No	ovember 1	5, 2007		
	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)										
		Christopher Mays, M.D., 183	,		•	. #207	, 01n	ey, Mai	cyland 20	832		
Stat	е	31. Date filed (Month, Day, Year) 32. Registr	rar's Signatu		bartes			-				
istra	ır	NOV 1 6 2007	ELARA D	( ) A	A CALL							

Registrar DHMH 17 Rev 1/2001 **Physic** /Med Exami

	Please Type or Print in B						ble.			
	For State of Maryland  1 - State Registrar		rtificate of			g. No. 2	07	36746		
	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month			Day	Year	3. Time of Death		
ian cal	Estella Ratiner		Nov. 8,				- ( D . II	4:00 PM		
ner	4a. Facility Name (If not institution, give street and number)	n h	4b. City, Town, or Location of Death			4c. County of Death  Anne Arundel				
	Heritage Harbor Nursing & Reha		et hirthday) If Under 1 Year   If Under 24 Hrs.   8 Date of Bi			9. Birthplace (State or Foreign				
	103-26-1558 <sup>1□ M 2</sup> ¶F 92	Yrs. Months Days Hours Min.			Feb. 9,	(Month, Day, Year) Country) Feb. 9, 1915 New York				
	Usual Residence of Decedent	100 City Town and continu					1	0d. Inside City Limits		
   	10a. State 10b. County 10c. City, Town or Location Annapolis							1 XYes 2 No		
recto	10e. Street and Number		10f. Zip Code		10	0g. Citizen of What Country?				
<b>Funeral Director</b>	2700 S. Haven Road	21401				Uni	.ted	States		
nera	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.				
T.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No		1 ☐ Yes 2X No	Specify:	, thous, oto.,	Specify: White				
d by	3 🛚 Widowed 4 🗆 Divorced Year or Dates:	16a Dagge	dostia Hausi Occur	ation		16b. Kind of Business/Industry				
lete	15. Decedent's Education (Specify only highest grade completed)	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				Top. Kind of Business/muustry			
Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Secretarial				Medicine			
Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, M	laiden Surnan	ne)			
To E	Samuel Isaacs					nk)				
	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
	Leigh Ratiner, Son  2331-2 Boston Street, Baltimore, MD 21224  20a Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State									
	1 Burial 2 Cremation 3 K Bemoval from State cemetery, crematory or other place)									
	4 Donation 5 Other (Specify) Medcure, Inc. 11/13/200/ Portland, Oregon  21. Signature of Furfral Perife Licensee M0111322. Name and Address of Facility Harman Funeral Service, PA									
	7221 Grayburn Drive, Glen Burnie, MD 21061									
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death									
	Immediate Cause (Final disease or condition	2 4	to thrive					Onset and Death		
П	resulting in death)  Due to (or as a consequence of the consequence of	uence of):				1				
L	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence)	stee						may yours		
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ience oi).					-			
	that initiated events c	uence of):	nce of):							
Sal E										
ledio										
Physician/Medical	23b. Was decedent pregnant 1 live birth 2 Fetal death 3 Fetopic pregnancy						te of deliv	ery Day Year		
sici	in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Ves 2									
Ph.	Part II. Other significant conditions contributing to death but not resu	tribute to t	he cause of death?							
d by		3 ☐ Pro	bably 4 Unknown							
etec					24a. Was ai	n 24b.	Were auto	opsy findings available		
Completed					autops perforr	ned?	prior to co death? 1 ∐ Yes	ompletion of cause of		
Be Co	25. Was case referred to medical 26. Place of Death (Check only one)									
To B	examiner? 1   Yes 25000							fy)		
	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	ıry Work?							
catic	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	me farm et	M 1 Yes 2 No				(Street and Number or Rural Route Number,			
artifi	4 Homicide determined 28e. Place of Injury - At no building, etc. (Specific	/// ( ) //					(Street and Number of Hural Houte Number, Fown, State)			
Medical Certification:	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
edic	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.	tion and/or ir								
5	29h Signature and title of certifier		29c. Licen	se number	2	<ol><li>9d. Date signe</li></ol>	d (Month.	Dav. Year)		

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Marrito, Pay Year) 2007

November 13,2007

Mirza Mohammed Nusairee, MD, 1401 Madison Park, Glen Burnie, MD 21061

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM#23a Per PHYS C873 11 16 07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MOTUEMBER 9, 2007 **Physician** 12:05A Edwin J. Reynolds, Jr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Examiner Baltimore Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1**X**M 2□F Davs Hours 11.13.1924 MD Director 217.16.6821 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Baltimore Towson Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21204 509 E. Joppa Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 BYes 2 □ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White Baltimore, Maryland 21215-0036 <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wholesale permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Hardware Salesman GED 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Reynolds, Sr. Margaret Getzendanna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17361 19a. Informant's Name/Relationship (Type. Print) 100 Luther Rd. Apt. 300 Shrewsbury, Janet L. Reynolds/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. | 11.13.07 | Beltsville, MD 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee Alternatives 8717 Green Pastures Dr. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Infection **Examiner** URINARY TRACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as the 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Atter this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Nnknown RENAL FAILURE 24a. Was an autopsy performed 1□ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 1 Natural 2 Accident Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Pruneral Director: filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Cortif D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 KHOSROW TABASSI M. D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2007 3674			
	Division		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death			
	Physici /Medi		Rose Mary Rutter November 14 2007 3:12a			
1	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death			
			4603 Leeds Avenue Apt 2 Carroll Baltimore			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) (State or Foreign (Month) Day Year)			
	Director		218-64-3849 52 Yrs.       6-3-1955 Maryland			
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits			
	//aryl	ō	MD Baltimore Carroll			
1	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	ect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?			
		Ö	1603 Tooda Arranya Ant 2			
	leath v ns 23a must	Funeral Director	0.0.11.			
(0	after o	Für	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.  1 □ Never Married 2 ☑ Married 1 □ Yes 3 ☑ No □ □			
ဗ္ဗ	urs a al', o Exan	by	3 □ Wildowed 4 □ Divorced   If Yes, Give 1 □ Yes 2 No Specify:   Specify: White			
9	n 72 hours ، "natural", c edical Exan	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Tohan Honking			
2	within ene. than "	g	Elementary/Secondary (0-12) College (1-4or 5+)			
7	e filed w al Hygier other th	S	1 /2 Fillebocomist			
Maryland 21215-0036	ld be fil lental H ked ott ic even	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  James L. Spilman  Magdalen (Knapp)			
$\frac{1}{2}$	2 should be and Menta is marked a	ု	inagatien (imapp)			
a	12 sh h and ris π		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
	s 1 and 2 should be filed within 72 hd if Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical		Gary K. Rutter/Husband 4603 Leeds Avenue Apt. 2 Baltimore MD 2122			
ğ	d) O L		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State   cemetery, crematory or other place)			
≣	t. Pa rtmer rtant:		1			
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		21. Signature of Funeral Serve Licensee  22. Name and Address of Facility Cvach/Rosedale Funeral Hom 1211 Chesaco Avenue Rosedale MD21237			
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of).			
68/60,	ficate be executed physician and sthe burial-transit	<u>is</u>	resulting in death) Last  Due to (or as a consequence of):  d			
C. Box	w requires that the death certificate be executed been signed by the attending physician and Eshould be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			
rds, P	requires that the sen signed by the rould be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Onknown			
Vital Records,	n: The law re ficate has bee or, page 2 sho		24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 Two  25. Was case referred to medical  26. Place of Death. Check col. one			
>	Attending Physician: r death. ector: After this certific. by the funeral director, i	To Be	25. Was dase referred to medical examiner?  1			
0	g Phy er this	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred			
5	nding th. r: Afte e fun	iti l	12 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
DIVISION	Hospital or 24 hours afte Funeral Dir etely filled in I	Medical Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
ŀ	To the within To the comple	Σ	29b. Signature and title of celetities 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yelena Lipnik, 720 Marchen Choice Care, Bak					
	Sta Registr	- 1	31. Date filed (Month, Day, Year)  NOV 1 6 2007  33 Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08048 State of Maryland / Department of Health and Mental Hygiene Thomas A. Reeves 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 15, 2007 1230 hrs Medical Examiner Thomas Albert Reeves 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland Months Davs Hours Min 213-44-4881 Director 01/12/1945 1 XM 62 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No or items 23a or 28a-f show must be notified at once.  $\mathbb{C}$ Washington Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 20019 U.S.A. 5043 B Street, S.E. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 X Married Yes Specify: Black If Yes, Give Year Yes 2 X No specify: nt of Health and Mental Hygiene. it: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 D.C. Government Janitor 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John C. Reeves Mary I. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5043 B Street, S.E.; Washington, D.C. 20019 Julia V. Reeves - Wife 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition timore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/22/07 Landover, Maryland Harmony Memorial Pk. Donation 5 Other Specify: 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee elman 4594 Beech Road; Temple Hills, Maryalnd 20748 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and fai ure. List only one cause on each line. /Medical Death Air embolism during dialysis Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and To the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial .27.28a-f. perME.g873. 11/19/07 TT Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Day Live birth 3 Ectopic pregnancy Month Fetal death Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 V Unknown þ Hypertensive atherosclerotic cardiovascular disease; chronic Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of obstructive pulmonary disease autopsy death? After this certificate has performed? Yes 2 1 🗸 Yes page 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Residence 6 Nursing Home 5 2 FR/Outpatient 3 DOA Inpatient 1 Yes ٩ 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death air embolism during dialysis 1 Natural Yes 2 X No 24 hours after death. Pending 10/15/2007 11:45 am Fo the Funeral Director: filled in by the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 or Town, State) 29 Minnesota Could not be Suicide D.C. determined (Specify) dialysis center Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DOME

en

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year)

6-6-

Assistant Medical Examiner

32 Registrar's Signature

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 16, 2007

07-08728 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Doris Margaret Royer 1. For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0626 hrs Medical Examiner Doris Margaret Royer November 10, 2007 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** Belair Road & Fullerton Avenue 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Davs Hours Director 59 April 10 1948 Country Maryland 216 52 7029 2 X F М Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Baltimore Baltimore County permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other reamatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15 W Elm Avenue 21206 LISA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 XX Married 2 X No Yes If Yes, Give Year Yes 2 No specify: White Specify: 3 Widowed 4 Divorced à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 12 N/A Housewife Housekeeping~Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Hetmann Margaret Elizabeth Klink Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) James M. Royer 15 W Elm Avenue (Husband) Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 XX Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. November 16 2007 Baltimore, Maryland Donation 5 Other Specify: 22. Name and Address of Facility Lassahn Funeral Home Inc 21 Signature of Funeral Service Licensee complications that caused the death. Do not ente Approximate Interval Part I. Enter the disea Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease ramine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED nttending physician or use as the burial -Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law remines المسابقة ال IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) for Yes 2 No 9 ✔ Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ signed be deta Š Yes 2 ✓ No 3 Probably 4 Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other DOA Nursing Home 5 Residence 6 🗸 Other: Scene

certificate has this After

ဥ Certification:

n 24 hours after death.

e Funeral Director: A steely filled in by the fu To the

W

Medical

31. Date filed (Month, Day, Year) State Registrar

1 Yes

27. Manner of Death

2 🗸 Accident

Natural

Suicide

Homicide 29a. Certifier 1

29b. Signature and title of certifu

Patricia Aronica-Pollak MD.

1

one)

30. Name and address of person who completed cause of death (Item 23a)

Pending

Investigation

Could not be

Assistant Medical Examiner 32. Registrar's Signature

28a. Date of Injury (Month, Day Year) Nov 10, 2007

and manner stated

(Specify) Major Road

ORIGINAL

ER/Outpatient 3

28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0615 hrs

28b. Time of Injury

28c. Injury at Work?

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

1 Yes 2 V No

28d. Describe how injury occurred

or Town, State) Belair Rd & Fullerton Ave, Baltimore, MD

28f. Location (Street and Number or Rural Route Number, City

November 10, 2007

29d. Date signed (Month, Day, Year)

Pedestrian struck by bus

State of Maryland / Department of Health and Mental Hygiene

		•	1- State Of Maryland		rtificate of i			2007	36751	
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death	
	/Medic		Gordon Lowell Smit	h			November		10:09A M	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death			4c. County of Death		
			1504 Crofton Parkway  5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	Crofton  VI If Under 1 Year   If Under 24 Hrs.   8, Date of Birth			Anne Arunde1		
4	Funeral Director		304-20-2831 1 X 2 F 82  Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	(Month, Day, )	<sup>(car)</sup> 1924 Kar	nplace (State or Foreign Intry) 1535	
	aryland show	J.	10a. State 10b. County 10c. City, Town or Location 10d. Insid						10d. Inside City Limits 1 ☐ Yes 2 No	
	the Marylar 28a-f show notified at	ectc	Maryland Anne Arundel	Crofton         10g. Citizen of V			g. Citizen of What Co			
	urs after death with al", or items 23a or Examiner must be I	ä			·	1 /	100	United St		
21215-0036		era	1504 Crofton Parkway  11. Marital Status  12. Was Decedent Ever in U.	.S. 13.	211 Was Decedent of H		ecify Yes or No-	14. Race - Amer		
		Completed by Funeral Director	Armed Forces?  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ※ No	an, Mexican, Puèrto Specify:	Rićan, etc.)	Black, White	e, etc. Lite	
Ö		ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup	ation	ing 10	6b. Kind of Business/l	ndustry	
215	thin 7 e. an "r Med	Jple	Elementary/Secondary (0-12) College (1-4or 5+)	- life.	kind of work done DO NOT use retired	d)	ing			
21	ed wil	Son	5+	Jo	urnalist				Relations	
pu	be file tal H d oth even	Be	17. Father's Name (First, Middle, Last)			_	e (First, Middle, Ma	,		
yla	Meni arke	ဥ	Howard Smith	1		Grace	Hender			
Maryland	12 sh h and 7 Is n traun	Ш	19a. Informant's Name/Relationship (Type. Print)					City or Town, State, 2		
	1 and Healt em 2		Mildred Patricia Smith/wife  20a. Method of Disposition 20b. F		Crofton  osition (Name of matory or other place			Maryland Oc. Location - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical once.		1 A Buria: 2 Oremation 3 Nemoval from State	dar Hi	11 Cemete	ry 11/15	5/2007	Suitland,	Maryland	
Balt	permit. Depart Import any inf		1. Signature of Funeral Service Licenses    22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113							
			23a. Part1. I nter the disease, or complications that caused the deat shock. I heart failure. List only one cause on each line.					st,	Approximate Interval Between	
	Physician /Medical Examiner	ee i	Immediate Cause (Final disease or condition resulting in death)  a. Due to (of as a consequence)	dial.	Infare	Ton			Onset and Deale J	
н		_	Sequentially list conditions, b.							
		Jine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence or):						
	and and	xan	Cause (Disease or injury that initiated events c	uence of):						
68760,	icate be executed	ledical Examiner								
687	tificate ig phys as the	edic								
.O. Box	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnate to 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of continuous political programmes and the pregnant at time of continuous programmes are pregnant at time at the pregnant at time and the pregnant at time are pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at the pregnant at the pregnant at time at the pregnant at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at time at the pregnant at the pregnant at the pregnant at time at the pregnant at the pregnant at time at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant at the pregnant a	al death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of del Month	very Day Year	
Δ.		by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the call t							
Ö		eted	Do to							
Il Records,		Completed by	24a. Was an autopsy finding prior to completion of death?  1 Yes 2 No 1 Yes 2 No						completion of cause of	
Vita	certificate ector, pag	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Oth		th (Check only one	)		
or Vital	ding Physician:  After this certific funeral director,	2	1 Yes 2 1 10 1 10 Inpatient 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpatie		4 LI Nursing Ho		nce 6 Other (Spe	cify)	
n	fing After fune	ion	1 ☐ Hatural 5 ☐ Pending (Month, Day Year)	Injury						
Division	or Attendiffer death	licat	3 Suicide 6 Could not be 28e. Place of injury - At h	ome, farm, st				treet and Number or Rural Route Number,		
Θį		ertil	4 Homicide determined building, etc. (Special	fy)						
_	Hospital 24 hours a Funeral etely filled	Medical Certification:	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the within 2 To the comple	Mec	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,						h, Day, Year)	
	F S F Ö		I forch Friend M.h		DI	7965		11/12/07	7	
	8+1	30. Name and address hipperson who completed cause of death (Item 23a) (Type, Print)  To see French 16 De Pense Huy Annyolis, WM - 21401							1	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature						- 170				
	Regist		NOV 1 C 2007	Break	وو					

DHMH 17 Rev 1/2001

hin 24 hours after death the Funeral Director: 2

DHMH 17 Rev 1/2001

12

State

Registrar

one

31. Date filed (Month

29b. Signature and title of certifier

DEME

29c. License number

29d. Date signed (Month, Dav. Year)

and manner stated.

Woods

32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print

Director

Be Completed by Funeral

ဥ

25. Was exam

27. Man

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

6 Could not be determined

Examiner

Be Completed by Physician/Medical

Certification: To

Medical

**Physician** /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** /Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure Al	l Copies Are Legible
State of Maryland / Department of Health and M	lental Hygiene
Registrar Certificate of Death	Reg. No. 2007 36753
Decedent's Name (First, Middle, Last)	Date of Death     3. Time of Death
WILLIAM THOMAS STATON	November 12, 2007 438 pm
4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
5. Social Security Number 6. Sex 7. Age (In vrs. last hirthday) If Under 1 Year 1 If Under 24 Her	N/A
1XXM 2 TF Months Days Hours Min	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Usual Residence of Decedent	Jan 6 1939 MARYLAND
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MARYLAND N/A BALTIMORE	iXXves 2 □ No
10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
727 DRUID PARK LAKE DR. 21217	U.S.A.
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 2 Never M	
Later married 2 walled	Black, White, etc.
3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 XXio Specify:	Specify: BLACK
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)	16b. Kind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	CARR LOWERY GLASS CO
12th grade MACHINE OPERATOR  17. Father's Name (First, Middle, Last)  18. Mother's Name	
io. model 3 realige	(First, Middle, Maiden Surname)
unknown  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number of Pint)	TATON
The same of the same same same same same same same sam	
PAULA D. FREEMAN/Daughter 3030 Grantley Ave., Ba 20a. Method of Disposition 20b. Place of Disposition (Name of Day 20b. Place of Day 20b.	ltimore, Md., 21215
1 ☐ Burial 2 ⚠ remation 3 ☐ Removal from State	ate 20c. Location - City or Town, State
4 Donation 5 Other (Specify) METRO CREMATORY 11-14	-07 BALTIMORE, MARYLAND
21. Signature of Funeral Service Licensee  22. Name and Address of Facility WILLIAM C BROWN COM	MUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest, Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Onset and Death
Due to (or as a consequence of):	
Sequentially list conditions, b. LIVER FATIUR C	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
resulting in death) Last	
Due to ( as a consequence of):	
d	
IF FEMALE:	
23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	23d. Date of delivery
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
Thrombo ruto o min. De a un Eristing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
growing, growe rancke	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
	24a. Was an 24b. Were autopsy findings available
	performed? performed? performed?
25. Was case referred to medical exampler?  26. Place of Death (C	
1 Pres 2 No Prospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
	d. Describe how injury occurred
2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	

The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760,

2 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vijaya Gud 31. Dele filed (Month, Day, Year) 32 Registrar's Signature NOV 1 6 2007

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 0 7 36754 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Joan Elizabeth Scalf 21:20 PM NOV 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE SINA HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days Hours Year) 1 □ M 2 👿 F 578-32-4017 67 1940 Washington DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA 6701 Wilmont Road Apt. T4 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) food service waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Harold Marsh Helen Larraine Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Y. Marsh (daughter) 6701 Wilmont Dr., Apt T4, Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Family Cemetery 11-16-07 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Dauge Haught Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END STACK DENAL DICEPACE LUPERTIENDON: MRIA

Physician /Medical Examiner Examiner

**Physician** 

/Medical

MD

Director

Funeral

δ

Completed

Be

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Injury or other traumatic event,

permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 Is
any Injury or other trau

death with the Maryland

Baltimore, Maryland 21215-0036

aftending physician and for use as the burial-trar signed to

Physician/Medical

5

Medical

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

Nilosh J. Patel mo

NILESH J. PATER MP.

NOV 1 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

ed	END STACE KEN	THE DISCIASE	HYPERIEN	3)0/0       11   K37	1 Yes 2	No3Probably 4 ★JUnknown					
Complete	BACTEREMIA, I	DECUBITUS UL	CER		24a. Was an autopsy performed? 1∐ Yes 2 ☑No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
Be	25. Was case referred to medical		26. Place of Death (Check only one)								
TO E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ER/Outpatient 3☐ [	Home 5 ☐ Residence 6	B □Other (Specify)						
	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		nome, farm, street, factorify)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,					
dical (	29a. Certifier 12 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)					

29c. License number

D 6495

SINAI HOSPITAL OF BALTIMORE

29d. Date signed (Month, Day, Year)

NOV. 11, 2007

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 20c, per FH, g873, 11/16/07 TT Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** VAN 17uss 1012 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of N/A Maryland Malical Center If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth (Month, Day, Year) FEB 11, 1942 Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☐ F 65 Virginia Director 223-48-8398 Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 10231 Baltimore National Pike 21042 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cashier Retail 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles VanHuss Golden P. Welch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Neary/daughter 1034 Lakemont Rd. Catonsville, MD 21228 20c. Location - City or Town, State

Elkridge, MD

Elkridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 N Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 11/16/2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Haight Funeral Home & Chapel, P.A.

105 Sykesville. MD 21784 21. Signature of Funeral Service Licenses (410-795-1400) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Sepsis week disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner per Kalemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as a consequence of Examiner that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 1∐ Yes 2 🗆 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie onel 29b. Signature and title of 29c. License number ertific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) vende 11 23 South Baltimore Greene onathan 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

07-08712 Constance Webster

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007	3	6	7	5	1
------	---	---	---	---	---

		1- For State Certificate	of Death	Reg. No	0.
Physicia	an/	Decedent's Name (First, Middle,Last)		Date of Death     Month Day	3. Time of Death
dical Exami		Constance Webster	Lu ou z a allaga de Bard	November 9, 2	2007 1025 hrs 4c. County of Death
		4a. Facility Name (if not institution, give street and number) 19960 A National Pike	4b. City, Town, or Location of Deat Hagerstown		Washington
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		rs. 8. Date of Birth(MN	W/DD/YYYY) 9. Birthplace (State or
Director		220 50 0570	Yrs. Months Days Hours Mi		Foreign
	H	Usual Residence of Decedent	1101	07/09/12	945
any		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	MD Washington Ha	agerstown		1 Yes 2X No
Maryl 28a-f	Director	10e. Street and Number	10f. Zip Code		itizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.		19960A National Pike	21740		nited States
th wil	Funeral		Was Decedent of Hispanic Origin? ( \$ If Yes, specify Cuban, Mexican, Puerl		14. Race - American Indian, Black, White, etc.
rer des		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2X No specify:		Specify: White
urs af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dece	dent's Usual Occupation (Give kind of		. Kind of Business/Industry
72 hc	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use re	etired)	
003 within iene.	틽	5+	Pharmacist		Medical
1215-0036 Id be filed within 72 Aental Hygiene. narked other than '		17. Father's Name (First, Middle, Last)  Roy Wollums		ne (First, Middle, Maide	
212 uld be Menta marka	To Be		iling Address (Street and Number of	ley Eileen Rural Route Number,	
and 2 should I teath and Mer ten 27 is man traumatic ev		Stephen Webster, Husband 1996	50A National Pike	, Hagerstow	wn, MD 21740
e, F. I and I healt Fitem		20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery, rother place)		c. Location - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		T Buriai 2 X Cremation 3 Removal non State		/14/2007 Ba	altimore, Maryland
Balti Departm Imports Imjury o	Ī	21. Signature of Funeral Service Licensee M01113	2. Name and Address of Facility Ho	arman Funei	ral Service, PA
			7221 Grayburn Driv	ve, Glen Bu	urnie. MD 21061
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest, s	Shock, or heart Approximate Interval Between Onset and Death
caminer	İ	Immediate Cause (Final disease or condition resulting in death)  Multiple Sharp Force Injuries  Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	<u>je</u>	if any, leading to immediate Due to (or as a consequence of):			
Tx _	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, icate be executed sphysician and the burial - transit		d			
760, icate be executed physician and the burial - transi	Medical	UNPENDED AMENDED			
760, ficate be g physicist the burn		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic preg		23d. Date of delivery  Month Day Year
Box 687 e death certifine the attending	Physician	past 12 months?  Pregnant at time of death 5	Other (Specify)	I	Month.
Bo e deat the at ed for	hys	1 Yes 2 No 9 Unknown g Unknown			
Division of Vital Records, P.O. Be tall or attending Physician: The law requires that the de irs after death.  al Director: After this certificate has been signed by the elector, page 2 should be detached for the year.	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		co use contribute to the cause of death?  No 3 Probably 4 Unknown
S, P.C puires that an signed	73			- 1 24a. Was an	24b. Were autopsy findings available
ord aw rec as bee	Completed		<del></del>	autopsy performed	prior to completion of cause of
Rec The I	ĕ			1 ✔ Yes 2	
Vital Records, sysician: The law requir his certificate has been sedirector, page 2 should	Be	25. Was case referred to medical examiner? Hospital: Innatient 2 FR/Outnat	26.Place of Death (Checkler 3 DOA Other: Nurs		· · · · · · · · · · · · · · · · · · ·
f Vit Physic er this eral din	-	1 ✓ Yes 2 No rospital 1 Inpatient 2 ER/Outpat 27. Manner of Death 28a. Date of Injury 28b. Time		sing Home 5 Resi	idence 6 🗸 Other: Scene
on of \nding Plry th. : After the funeral	<u>.</u>	1 Natural 5 Pending FOUND: Day, Year) FOUND	1 Yes 2 ✔ No	Subject stabbe	
risic r Atte er dea rector	licat	2 Accident Investigation Nov 9, 2007 1025 nrs		28f. Location (Stree	et and Number or Rural Route Number, City
Division pital or Attent ours after death teral Director:	Certification:	Suicide 6 Could not be determined (Specify) Single Family Hom	е	or Town, State 19960 A National	Pike, Hagerstown, MD
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death o	ccurred at the time, date and place, a	nd due to the cause(s)	and manner as stated.
To the Hos within 24 h To the Fur	ledical	one) 2 Medical Examiner:On the basis of examination and/or inves and manner stated.			
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		d. Date signed (Month, Day, Year)
		Donna Mincenti, MID,	U.O.IVI.L.		
B		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201	
s	ate	31. Date filed (Month, Day, Year) 32.33 sistrar's Signature	9 10		
Regis		NION B B DOOT   See A	COME		

State of Maryland / Department of Health and Mental Hygiene

2:30 PM

9. Birthplace (State or Foreign

10d Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

1 ☐Yes 2 ☑ No

2007

Poland

Black, White, etc.

White

Division or Vital Records, P.O. Box 68760

or Attending Physician: Director: After the Certification: filled in by the Hospital 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M (0 D30132 November 13, 2007 30. Name and a thress of person who completed cause of death (Item 23a) (Type, Print) Physicians Lame #161, Rockville, Maryland 20850 Rita Ghosh, M.D., 14812 32. Registrar's Signature Year) State The product Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day WALTER A. WINKLER NOV. ,2007 3:03P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2223 WALSHIRE AVE BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 229 09 Yrs 6917 87 dec.3,1919 VIRGÍNIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2223 WALSHIRE AVE. 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heaith and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show Physic

Baltimore, Maryland 21215-0036

**Physician** 

/Medical

**Examiner** 

10a. State

MD.

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

þ

/Med Exam

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h

Division or Vital Records, P.O, Box 68760

=	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	<i>'</i>									
	5TH		STEELW	ORKER		BETH	ILEHEM	STEEL (					
מ	17. Father's Name (First, Middle, Last)				ame (First, Middle,								
	PRESTON WIN	KLER		IREN	E STREET	STREET							
	19a. Informant's Name/Relationship (T	ype. Print)	19b. Mailing Addre	ess (Street and Number or I	Rural Route Numb	er, City or T	own, State, Zip	Code)					
	EVA D. WINKLER	(wife)	2223 W	ALSHIRE AVE	E. BALTO	O.MD.	21214						
	20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ I		Place of Disposition (fi cemetery, crematory of	lame of	Date	20c. Loca	tion - City or Tov	vn, State					
	4 □ Donation 5 □ Other (Specify	hemoval from State	RKWOOD C	' ' '	. 20,20	0.7	BALTO,	MD					
	21. Mature of Funeral Service Licens	see //	22. Name	and Address of Facility				110.					
	1 Ilvarilleno	RAL H	OME	0.7.0									
1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between												
ĺ	Immediate Cause (Final Onset and Death												
	resulting in death)	resulting in death)  a. Due to (or as a consequence of):											
		240 10 (01 40 4 0011004	acrioc oi).					,					
	Sequentially list conditions, if any leading to immediate	b. — Due to (or as a consex)	renge of										
	cause. Enter Underlying Cause (Disease or injury												
	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):										
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    IF FEMALE:													
	IF FEMALE:												
23b. Was decedent pregnant in the past 12 months?  1													
İ	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta	I death 3 ☐ Ectopic	pregnancy		1							
		1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3 ☐ Ectopic eath 5 ☐ Other	spregnancy (specify)									
	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	4☐Pregnant at time of d 9☐Unknown  ontributing to death but not resi	eath 5 Other	(specify)	23e, Did to		Month [	Day Year					
	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	4☐Pregnant at time of d 9☐Unknown  ontributing to death but not resi	eath 5 Other	(specify)		obacco use	Month [	Day Year e cause of death?					
	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown  ontributing to death but not resi	eath 5 Other	(specify)			Month [	Day Year e cause of death?					
	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	4☐Pregnant at time of d 9☐Unknown  ontributing to death but not resi	eath 5 Other	(specify)	1 ☐ `	obacco use	Month I	Day Year e cause of death? ably 4 ∐Unkno					
	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions co	4☐Pregnant at time of d 9☐Unknown  ontributing to death but not resi	eath 5 Other	(specify)	1 ☐ `	obacco use	Month I	e cause of death?  ably 4 Unknows sy findings availal interest of cause of					
	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co	4 □ Pregnant at time of d 9 □ Unknown  Intributing to death but not res	eath 5 Other	g cause given in Part I.  26. Place of Do	24a. Was autor	obacco use  /es 2      an  ssy  rmed? 2   1000	contribute to the No 3 Proba 24b. Were autop prior to com death?	e cause of death?  ably 4 Unknows sy findings availal interest of cause of					
	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co	4 Pregnant at time of d 9 Unknown  Intributing to death but not resident the property of the p	eath 5 Other	g cause given in Part I.  26. Place of Do	24a. Was autop perfo	obacco use  fes 2     an ssy rmed? 2     2       No	contribute to the No 3XProba 24b. Were autop prior corr death?	Pay Year  e cause of death?  ably 4 □Unknow  sy findings availal  pletion of cause of					
	in the past 12 months?  1   Yes   2   No    9   Unknown  Part II. Other significant conditions cond	4 □ Pregnant at time of d 9 □ Unknown  Intributing to death but not resident to the property of the property of the property of the pregnant at time of d 9 □ Unknown	eath 5 ☐ Other	g cause given in Part I.  26. Place of Do  Other: 4 \( \triangle \text{ Nursing} \)	24a. Was autor performed to the control of the cont	an symmed? 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	contribute to the No 3 Proba 24b. Were autop prior to comdeath? 1 Yes 2	Pay Year  e cause of death?  ably 4 □Unknow  sy findings availal  pletion of cause of					
	in the past 12 months?  1	4 □ Pregnant at time of d 9 □ Unknown  Intributing to death but not resident of the property	eath 5 Other  Ulting in the underlying  S. S. C.  ER/Outpatient 3 1 28b. Time of	g cause given in Part I.  26. Place of Do	24a. Was autor performent of the control of the con	an symmed? 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	contribute to the No 3 Proba 24b. Were autop prior to comdeath? 1 Yes 2	Pay Year  e cause of death?  ably 4 □Unknow  sy findings availal  pletion of cause of					
	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  CORONARY A  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending	4 □ Pregnant at time of d 9 □ Unknown  Intributing to death but not resident of the second of the s	eath 5 Other  Ulting in the underlying  S. S. C.  ER/Outpatient 3 1  28b. Time of Injury  M	26. Place of DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	24a. Was autor period 1 Yes eath (Check only of 28d. Describe I	obacco use  /es 2     an     ssy     rmed?     2       who injury of the continuous injury of th	contribute to the No 3 Proba 24b. Were autop prior to comdeath? 1 Yes 2	Pay Year  e cause of death?  ably 4 □Unknow  sy findings availal  pletion of cause of					
	in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  CORMAY  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death 1   Natural 5   Pending investigation 3   Suicide 6   Could not be	4 □ Pregnant at time of d 9 □ Unknown  Intributing to death but not resident of the property	eath 5 Other  Ulting in the underlying  S. S. C.  ER/Outpatient 3 1  28b. Time of Injury  M	26. Place of DOA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	24a. Was autor performed to the performed to the performance of the pe	obacco use  /es 2     an     ssy     rmed?     2       who injury of the continuous injury of th	contribute to the No 3 Proba 24b. Were autop prior to condeath? 1 Yes 2	Pay Year  e cause of death?  ably 4 □Unknow  sy findings availal  pletion of cause of					
	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  COCOMAY  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death   Natural 2   Accident 3   Suicide 4   Homicide    29a. Certifier 1 Certifying Phy	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifications)	ER/Outpatient 3 (Injury)  Mome, farm, street, fact	26. Place of Do ODA Other: 4 \( \triangle \text{Nursing} \)  28c. Injury at Work? 1 \( \triangle \text{Yes} \) 2 \( \triangle \text{No} \)  ory, office	24a. Was autop performed to the performance of the	obacco use  /es 2     an   ; syrmed? 2     dence 6     fow injury of the course of the	Month [  contribute to the  No 3 Probe  24b. Were autop  prior to com  death?  1  Yes  Other (Specify)  Docurred	Pay Year e cause of death? ably 4 Unknowsy findings availal appletion of cause of the cause of t					
	in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions co  COCOMAY  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manner of Death   Natural 2   Accident 3   Suicide 4   Homicide    29a. Certifier 1 Certifying Phy	Hospital:  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifical policy)	ER/Outpatient 3 (Injury)  Mome, farm, street, fact	26. Place of Do ODA Other: 4 \( \triangle \text{Nursing} \)  28c. Injury at Work? 1 \( \triangle \text{Yes} \) 2 \( \triangle \text{No} \)  ory, office	24a. Was autop performed to the performance of the	obacco use  /es 2     an   ; syrmed? 2     dence 6     fow injury of the course of the	Month [  contribute to the  No 3 Probe  24b. Were autop  prior to com  death?  1  Yes  Other (Specify)  Docurred	Pay Year e cause of death? ably 4 Unknowsy findings availal appletion of cause of the cause of t					
٠	in the past 12 months?  1	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specificials: To the basis of examina inter: On the basis of examina	ER/Outpatient 3 28b. Time of Injury Mome, farm, street, fact wiedge, death occurration and/or investigati	26. Place of Do ODA Other: 4 \( \triangle \text{Nursing} \)  28c. Injury at Work? 1 \( \triangle \text{Yes} \) 2 \( \triangle \text{No} \)  ory, office	24a. Was autop performed to the coursed at the time,	obacco use  /es 2       an     ssy	Month [  contribute to the  No 3 Probe  24b. Were autop  prior to com  death?  1  Yes  Other (Specify)  Docurred	Pay Year  e cause of death?  ably 4 Unknor  sy findings availal pletion of cause of  Poute Number,  ated.  the cause(s)					

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: To the Fun within 2

2

30. Name and address of person who complete Ava A. Kaufman,

29b. Signature and title of certific

MD

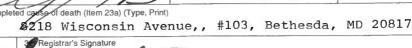
2007

29a. Certifier

Medical

State

Registrar



XXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

D26259

29d. Date signed (Month, Day, Year)

October 31, 2007

State of Maryland / Department of Health and Mental Hygiene 007 36760 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5:00 P.M **Physician** October 30, 2007 Hamida Zahur Alam /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery 13738 Notley Road If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Dec. 13, 1934 Days Information Information 1 ☐ M 2 🔭 F 72 216-62-8888 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene.
ant: If item 27 ie marked other then "naturel", or iteme 23e or 28e-1 ehov ury or other traumatic event, it is Medical Exam are must be notified at 28a-f show Silver Spring Maryland Montgomery 1 ☐ Yes 2 ☐ No Directo 10e. Streel and Number 10g. Citizen of Whal Country? 10f. Zip Code United States 20904 13738 Notley Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ÑNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: Asian Pacific 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Pathologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fatima Bibi Mohammad Shafi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17621 Auburn Village Drive Sandy Spring, Md. 20860 permit. Pages 1 and 2 a Department of Health at Important: If item 27 le eny Injury or other trau Zohair Alam -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 10/31/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA eld 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Belween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and the burial-transit The law requires that the death certificate be executed Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the e P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ 3 Probably 4 Unknown 1 ☐ Yes 2 No certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural 2 Accident Injury To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer D0014556 10.30.07 15200 New Hampshise Ave Silver Springs MD 20905 30. Name and address of person MUHAMMAD completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 0 1 State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 Day Month 11 2007 **Physician** RUTH BREIDENBAUGH 9:20 A M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Min. Days Hours 1 □ M 2 🕱 F 88 14,1919 Maryland 213**-**12**-**4778 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Jarrettsville Harford Director MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21084 United States 2062 Harris Lane Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Butterwort Grayson Tarr Louise William ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 19a. Informant's Name/Relationship (Type. Print) 2062 Harris Lane (Dau.) Jarrettsville, MD. Deborah Ann Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jarrettsville Cem.ll/14/07 Jarrettsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S. ce Licensee 22. Name and Address of Facility Jarrettsville, Maryland der Kurtz & Son Funeral E.G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician intracram /Medical Due to (or as a consequence of): Examiner head Torum Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No certificate the Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Natural Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ne Funeral Director; A

bletely filled in by the ft. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 9 November 12 2007 D3551 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN 615 W. MACPHAIL ROAD BEL AIR, MD 21014 Registrar's Signature 31. Date filed (Month, Day, Year) State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** 9:26 PM 24, Alberta J. Cassell Butler 2007 Oct. /Medical 4a. Facility Name (If not institution, give street and number)
Summerville Assisted Living 4b. City. Town, or Location of Death 4c. County of Death Examiner Bowie

| Houndar 1 Year | Houndar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 27, 1926 | 9. Birthplace (State Grountry) | Washington, D.C. 14997 Health Center Drive 7. Age (In yrs, last birthday) 6. Sex **Funeral** 1 ☐ M 252 F Yrs. Director 579-42-6406 81 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 No Director N/A DC Washington, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1831 Varnum St., Funeral N.E. 20018 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Deperment of Health and Mental Hygiene. Important: If item 27 ie marked other than "ne eny injury or other treumatic event, the Madic 2008. Elementary/Secondary (0-12) College (1-4or 5+) Naval Architect U.S. Navy Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert I. Cassell Martha Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mira Shanks / Daughter 14143 Pleasant View Drive, Bowie, MD 20720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Lincoln Memorial Cem. Nov. 2, 2007 Suitland, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses Undra 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhilated events resulting in death) Last Examiner Due to (or as a consequence of). ed by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown sete hes been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XIUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? this certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: After this certifical funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Living Hospital: ۵ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760 within 24 hours after deat To the Funeral Director: filled in by the

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and vite of certifier 29c. License number 29d. Date signed (Month, Day, Year) D57028

tditya Chopra

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 26 2007 October IZELL BULLOCK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington WASHINGTON COUNTY HOSPITAL 9. Birthplace Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year J If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 1**▼** M 2□ F 80 Director 3/04/27 Rocky Mount, NC 728-12-8828 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 'natural', or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 No DC Washington Director None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20001 USA 2201 - 12th Street, N.W. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No 3altimore, Maryland 21215-0036 Specify: Specify: Black ģ 3₩idowed 4 Divorced Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Carpenter 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carol Ellis Robert Bullock ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1605 Fenwood Avenue - Oxon Hill, MD Trabian Short/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 11/05/07 Riverdale, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Facular Service 3821 - 14th Street, N.W., Washington, DC 20011 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Part I. Enter the disease shock, or heart failure. Immediate Cause (included is ease or condition resulting in death) ESPIRATERY Physician /Medical Due to (or as a consequence of): Examiner PREUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed RESISTANT STAPHYLO COCCUS METHICI UN burial-trar Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760 SEIZURE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an DI (BATE-1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. n 24 hours after death. he Funeral Director: A pletely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 EART ANTIETHM ST. HOTHOUND ME

State Registrar 31. Date filed (Month, Day, Year)

NOV 01

ANTALO WINDU (Pear) 3 Registrar's Signature

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 08:33 A M 2007 Gertrude /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year, 6. Sex **Funeral** 1 ☐ M 2 🗓 F 85 Philadelphia, PA 165-12-1868 1921 5. Director Dec. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23a or 28a-f show ner must be notified at 1 Yes 2 No Silver Spring Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 3212 Birchtree Lane U.S.A. 'natural', or Items 23a dical Examiner must by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other trainment. 18. Mother's Name (First, Middle, Maiden Surname)
Fva Goldstein 17. Father's Name (First, Middle, Last) Be Eva Morris Meckler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3212 Birchtree La., Silver Spring, MD 20906 19a. Informant's Name/Relationship *(Type. Print)* Carol Zagnit / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Shalom Memorial Park Nov. 2,2007 Lower Moreland, PA 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 D Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fune - Servic: Licenses 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to ( r as a consequence of) 5 days disease or condition resulting in death) DILEUMENTO /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe performed? 1☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 10 D006402 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falk Drive Rockville, MD Day, State 01 Registrar

State of Maryland / Department of Health and Mental Hygien 36765 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 2007 11:58 pm Dora C. Bitzel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Westminster Carroll Beverly Living Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Dec 09 1916 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1□M 2↓F MD Yrs. 90 214-14-6444 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County r then "naturel", or Items 23a or 28a-f ehow the Medical Examinar noust be notified at 1 ☐ Yes 2√2 No Director Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 1234 Washington Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Carroll County 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Hospital 6 Dietary Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be 17 is marked of trsumatic ever Mary Bloom George A. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: if item 27 is any injury or other trau 1401 Old Westminster Pike Westminster, MD Hilbert Bitzel/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/02/2007 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Trinity Lutheran Church Cem Westminster, MD 4 □ Donation 5 □ Other (Specify) 21. Sign tune of Funeral Service Licensee Friends Furier and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Parit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or asse consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year 5 Other (specify) 4☐Pregnant at time of death o ed by the a 9□ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes : After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this မ 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier d cause of death (Item 23a) (Type, Print) (188 Poole Rd, Wistmister MD W. Middleton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Germ It Spark Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State

Registrar

Dr. Kae Aung

31. Date filed (Month, Day, Year)

NOV 0 8 2007

ORIGINAL

32. Begistrar's Signature

Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician Bigler  $P^{M}$ Elisabeth November 5, 2007 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 24,1920 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1□M 2 F 578-90-4480 87 Director Germany Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifled at 1 ☐ Yes 2 € No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29602 Dogwood Circle 20659 Funeral Austria Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2EXNO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No à Specify: White 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Homemaker</u> Own Home Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event, <u>t</u> once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Schumacher Gertrude Mohlberg ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gertrude E. Kemp/Daughter 29602 Dogwood Circle, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Ceme. 11/9/2007 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bbinsfield-Echols Funeral Home PAA11, MD 20622 M00817 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a co physician a the burial-1 P.O. Box 68760 Physician/Medical as IF FEMALE: If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) by the a 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? a. Was an cate has t autopsy performed? certificate 2□ No 1 Yes 1□ Yes 2 **2**No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in the Hospital 29a. Certifier 🕝 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day Year) 29b. Signature and tle of certifier 29c. License number

State

DHMH 17 Rev 1/2001

Registrar

30. Name and add

31. Date filed (Month

James

Jarboe,

Day, Year)

Three Notch Road., Hollywood, Md

20636

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

240B5

		•	For State Registrer	State of Marylan	•	artment of H			giene 007	3.6768
	Physici	an	1. Decedent's Name (First, Middle, Last,  Ismat Bal		noudhu	ırv		2. Date of Dea Month 10-2	th	3. Time of Death 10:50p M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	loudife		r Location of Death		4c. County of De	eath
	Funeral Director		5//-92-1902	7. Age (In yrs.) 3 M 2 X F 6 2	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 10 – 22	9. E 7, Year) -1945 I	Birthplace (State or Foreign Country) ndia
	Maryland -f show iled at	tor	Usual Residence of Decedent           10a. State         10b. County           Md.         Montgom		y, Town or Lo tomac	cation				10d. Inside City Limits 1 ☐ Yes 2 No
	with the	i Direc	10e. Street and Number 918 White Pi	ne Pl.		10f. Zip Code 208	54		U.S.A.	Country?
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba I □ Yes 2⊠ No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ar Black, W	merican Indian, hite, etc. Asian
Baltimore, Maryland 21215-0036	within 72 hou lene. than "natura the Madical E	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+) 5 +	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired Cher	ation during most of won	king	16b. Kind of Busines	ss/Industry
yland 2	ould be filed Mental Hygi arked other atic event, t	To Be Co	17. Father's Name (First, Middle, Last) A . S . M . Os	sman			18. Mother's Nam Hamida		Maiden Surname) M	
Man	aith and 2 sho		19a. Informant's Name/Relationship (T) Naveen B. Choud			-			r, City or Town, State tomac <b>,</b> Md	
more	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	emetery, cren	sition (Name of natory or other place ashingt	on 10/3	Date 0 / 0 7	20c. Location - City Adelphi,	
Balti	permit. I Departm Importar any Injur		21. Signature of Funeral Servicin Licens		22	Name and Addre	ss of FacilityUni	versal	II Mort	uary Inc. 20011
	Physician	8 .	23a. Part 1. Enter the disease, or composhock, or heart failure. List only o	ne cause on each line.				or respiratory ari	rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. <u>Malignan</u> Due to (or as a conseq		arcinoi	u			2 years
8760,	icate be executed physicien and s the burial-transit	ical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a con						
P.O. Box 68	The law requires thet the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnancy	,		23d. Date of o Month	delivery Day Year
	w requires thet been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause giv	ren in Part I.			to the cause of death?  Probably 4 □Unknown
Division of Vital Records,		Completed						24a. Was a autop perfor 1 Yes	sy prior t med? death	autopsy findings available to completion of cause of ? es 2 \( \text{N} \) No
Zi Ki	Physician: r this certificatal director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:	ER/Outpatien	t 3 DOA Oth	00	th <i>Check only or</i>	ne) lence 6 Other (S	pecify)
ion of	Attending Phy ir death. ector: After this by the funeral of		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor			ow injury occurred	, , , , , , , , , , , , , , , , , , ,
Divis	i Ditte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of		eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospital within 24 hours a within 24 hours a completely filled	edicai	29a. Certifier 1 IX Certifying Phy (Check only one) 1 IX Certifying Phy 2 ☐ Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	n occurred at the til vestigation, in my o	me, date and place prinion, death occu	, and due to the or rred at the time, o	cause(s) and manner date and place, and c	as stated. due to the cause(s)
) (	To the within 2	Me	29b. Signature and title of certifier	1	)	29c. Licens D 4 5		2	29d. Date signed (Mo	
			30. Name and address of person who co	ompleted cause of death (Item 1221 Merca		-	Largo,	Md. 2	0774	
4	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1 200	32 Registrar's Signa	ture		- 1			

07-08650 Michelle Cooke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

	2	0	0	7	3	6	7	6	
--	---	---	---	---	---	---	---	---	--

			- For State Certificate C	f Death	Reg. N			
Pi Medical E	hysicia Examir	n/	1. Decedent's Name (First, Middle,Last)  MICHELE C. COOKE Michelle Cook		2. Date of Death Month Day November 6,	Year 2007	3. Time of Death 2159 hrs	
· )		•	4a. Facility Name (if not institution, give street and number)  Bowie Health Center	4b. City, Town, or Location of Deat Bowle		4c. County of Death Prince George's		
	ineral rector		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $1 \text{ M} 2_{\text{K}} \text{ F}$ 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr Months Days Hours Min			place (State or WASH.	
ryland	28a-f show any l at once.	Ī	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  MD PG  10e. Street and Number	OWIE	10g. (		10d. Inside City Limits 1 Yes 2 No	
the Ma	3a or 28 otified a	Dire	7516 OLD CHAPEL DRIVE	20715		USA		
fter death with t	l", or items 2 ter must be n	Fune	1 Never Married 2 Married Armed Forces? If	las Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert Yes 2 🔀 No specify:	o Rican, etc.)	14. Race - Americ White, etc.  Specify: BLA	CK	
<b>36</b> hin 72 hours a	e. than "natura edical Exami	Completed by	Flementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give kind of most of working life. DO NOT use re IOMEMAKER		n/a	dustry	
15-0036 filed within 7	Hygien ed other t, the Mo		17. Father's Name (First, Middle, Last)  RALPH M. COOKE JR.		ne (First, Middle, Maid			
MD 2121	h and Menta 27 is mark umatic even	To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailit CARMEN BARNES/DAUGHTER 751	ng Address (Street and Number of	Rural Route Number	City or Town, State,	20715	
Baltimore, P	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State crematory or RIVERDALE	osition (Name of cemetery, other place)  E. P.K., CREMATOR.  Name and Address of Facility	Y 11/13/		RDALE MD.	
Bal	Depar Impo injury	1		3435 14th ST.,	N.W. WA	SH. D.C.	20010	
/Me	sician edical miner	3 (0	23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	r the mode of dying, such as cardiac	or respiratory arrest,	snock, or neart	Approximate Interval Between Onset and Death	
ted	l insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Interstitial invocardia Due to (or as a consequence of):  C. Due to (or as a consequence of):  d.	l fibrosis				
8760, tificate be executed	physici he buri	=	X UNPENDED X AMENDED #1.PI line a-b, 27, per 15 FEMALE: 23c. If yes, outcome of pregnancy	ME,g875, 1/4/08 TT  Fetal death 3 Ectopic preg	nancy	23d. Date of delivery	/ Day Year	
. Box 687	has been signed by the attending 2 should be detached for use as I	Physician		Other (Specify)  e underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
5, P.O.	signed b	ठ	Tata. Other signmount conditions		-	130000000000000000000000000000000000000	bably 4 V Unknown	
of Vital Records, g Physician: The law requir	cate has been page 2 should	Completed			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of	
cian:	certifi ector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient	26.Place of Death (Cherent 3 DOA Other Nur		sidence 6 Othe	r·	
	_ < 2	tion: To	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time (Month, Day, Year)		28d. Describe how		·	
Division lospital or Attendi	ours after death eral Director: filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, s		or Town, Stat	e)	ural Route Number, City	
To the Hos	- 5 5	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death or one)  Medical Examiner: On the basis of examination and/or investigation and manner stated.	curred at the time, date and place, a gation, in my opinion, death occurre	and due to the cause(sed at the time, date an	s) and manner as stat d place, and due to th	ned. ne cause(s)	
<u>۾</u>	wi To	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Mo</i>		
12 F:	3)			enn Street, Baltimore, MD	21201			
			31. Date filed (Month, Day Year) 32. Registrar's Signal te					

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 Physician Oct. Emma Aileen Crandell 29 7:50 АМ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Mallard Bay Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov. 1, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F Maryland Yrs. 86 214-16-4979 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director Maryland Dorchester East New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5939 Heritage Road 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 1 ☐ Yes 2 ŽÑNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Day Care Assistant Child Care permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any njury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Clifton Winfield Burton Lillie Rebecca Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ivan W. Crandell, Sr./Husband 5939 Heritage Road, East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 11/1/2007 4 ☐ Donation 5 ☐ Other (Specify) East New Market, MD <sup>22. Name and Address of Facility</sup> Zeller Funeral Home, P. O. Box 207 106 MainStreet, East New Market, MD 21. Signs tury of Funeral Service Line 21631 Approximate Interval Between Onset and Death 23d. Pand. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Renal Failure 1 Month /Medical Due to (or as a consequence of): Examiner Clostridium Difficile Colitis I Week Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been signated page 2 should b 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 \( \overline{\Delta} \) No this certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 XNatural 5 Pending death. 1 Tyes 2 □No investigation 2 ☐ Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospitel 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Cambridge, MD21613 Patricia A John 31. Date filed (Month, Day, Year) 32. Reg State NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Phyllis Jean Dean 9. 2007 11:05A.™M /Medical November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Reeders Memorial Home Boonsboro Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Days 1 □ M 2**X** F Months Hours 235-40-6447 Director 79 1928 July 16, Ohio Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☑Yes 2 ☐ No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 5120 General Stuart Court 21782 U.S.A.Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 5 ME: DEAN THYLLT Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natu Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 4 Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Glen Parker ၉ Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Candice Edwards (Daughter) 5120 General Stuart Crt. Sharpsburg, MD 21782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department o Important: If any Injury or November Smithsburg, Maryland Smithsburg Crematory 12, 2007 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STROKE **Physician** DAYS /Medical Due to (or as a consequence of) Examiner AD VANCED DEMENTER YEMES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed physician and the burial-transi HYPERTENSION Due to (or as a consequence of): Box 68760, Physician/Medical MEUNS 4 6H4 as IF FFMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 BNo Month Day Year signed by the a 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 No Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after death.

al Director: After a by the funera Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division or Vital Records, To the Hospital o within 24 hours aff To the Funeral D

State

Registrar

Ghazala Qadir

(Check only one)

29b. Signature and title of certifier

29c. License number D46561 29d. Date signed (Month, Day, Year) 200 t

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Boonsboro, MD 21713 301-432-8470

20311 Lappans Road, 31. Date filed (Month, Day, Year) NOV 1 6 2007 32. Registrar's Signature

		Pleas	se Type or Prin					_		egible.	
		1 - For State Registrar	State of Ivia	aryian		artment of F rtificate of		vientai ny	giene Reg. No. 2	007	26772
300		1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	001	3. Time of Death
Physici /Medio		PATRICIA A	DAWSON					Month / /	Day 7	Year 2007	7:05 A M
Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Death	1	4c. Cc	ounty of Death	
		SHOCK TRAUMI	A CENTER				MORE				
Funeral		1	6. Sex 7. Age		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 2	th ly, Year)	9. Birth	place (State or Foreign ntry)
Director	ķ.	179-26-0168 Usual Residence of Decedent			74 Yrs.			July 2	0, 193	4 Penn	sylvania
and ow		10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
Mary f sho	호	Maryland Cecil			Pevry	111990					1 XYes 2 □ No
r 28a	Director	10e. Street and Number		l	· Oug	10f. Zip Code			10g. Citizer	n of What Cou	ntry?
h with		741 Aiken Avenu	Le Apt. #3			21903			u.s.A	V.	
death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No		Race - Ameri	
after or ite mine		1 ☐ Never Married 2 ☐ Marri		No 19!	54-	1 ☐ Yes 2 🛣 No	Specify:	o nicari, etc.)		Black, White,	-
ours rral", Exa	d by	3 ☐ Widowed 4 🂢 Divorced	Year or Dates:	19	55	1 1 1 63 2 120 40	эреспу.		St	pecify: Wh	ite
72 h "natu dica	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	- 4	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind	of Business/Ir	ndustry
withir ene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5	i+)		DO NOT use retired	a)		Darte		
filed Hygid	ပ္ရွိ	17. Father's Name (First, Middle, L	_ast)		Cress	Trainer	18. Mother's Nan	ne (First, Middle		want	
d be ental ced o	o Be	James T. Fox,	ŕ				Catherin	•			
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland in marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	ပ္	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street				own. State. Zi	n Code)
and 2: ealth a n 27 is er trau		James T. Fox, 1	II. (Brothe	/L)		Hares Hi					•
s1a of Hea item othe		20a. Method of Disposition				osition (Name of matory or other place		Date		ion - City or T	
Pages 1 nent of H nt: If ite		1 ☐ Burial 2 ☐Cremation 4 ☐ Donation 5 ☐ Other (Sp				ris & Co.	1	/2007	West	Chesto	n PA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L	icensee		22	2. Name and Addre	ss of Pacility ma	n Nitch	ell Sn	vith Fu	neral Home
9 <b>3 1 6</b> 8		disasc	stt - Cole	na	1	23 S. Was	hington	St. Hav.	re ad	Grace,	MD 21078
		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that caused only one cause on each lin	the death	n. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			ich Ac	cident		north	_ V-	(0)0	Onset and Death
/Medical		resulting in death)	Due to (or as a	a consequ	uence of):	-		31 De 31	AMINE		7 (10/3
Examiner		Sequentially list conditions.	b. Hult. Due to (or as a	pla	MUSICS		ng, such as cardiac	EDICAL			7 don-
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	al consequ	ience of):		el el	TED BY M.			
be executed ician and burial-transit	хап	that initiated events resulting in death) Last	c	a conseni	ience of):		M N APPR				
	-				31,0		TIFICATION				
death certificate attending physi	Physician/Medic	W.	d				CERT.				
nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome i						23d	. Date of deliv	erv
death atte	icial	in the past 12 months? 1 ☐ Yes 2 🛣 No	1 ☐ Live birth 4 ☐ Pregnant at			∃Ectopic pregnancy ∃Other (specify)	у			Month	Day Year
t the	hys	9 ☐ Unknown	9□Unknown								
ires that the de signed by the a f be detached t	by P	Part II. Other significant condition	ns contributing to death bu	ut not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did	obacco use	contribute to t	the cause of death?
w require been sig	edt							1 🗆	Yes 2	No 3□ Pro	bably 4 □Unknown
law re as be 2 sho	Completed							24a. Was	an 2	24b. Were auto	opsy findings available ompletion of cause of
The ate ha	E					***		auto perfo 1⊟ Yes	ormed?	death?	2 No
sian: ertifica ctor, I	Be C	25. Was case referred to medical examiner?					26. Place of Dea				20.00
hysic his ce	To	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 □ E	ER/Outpatien	nt 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 ☐ Resi	dence 6 □	Other (Speci	fy)
ing P		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	Worl		28d. Describe			0
tend leath. tor: / the fi	Certification:	3 Suicide 6 Could no	1101/20		12:46	3 <sup>PM</sup> 1	Yes 2 No	Moke V	check	Accid	ent
or At fiter d Direct in by	Ħ	4 ☐ Homicide determin	ned 286. Place of inju		me, farm, str	eet, factory, office		28f. Location ( City or To	Street and N wn, State)	lumber or Run	al Route Number
pital		29a. Certifier 1 Certifying	Physician: To the best of	treet	wlodgo dostl	h accurred at the tir	mo data and place		Rost	1 40/	PA Stek Line
24 hc 24 hc 8 Fun etely	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examinat	ion and/or in	vestigation, in my o	opinion, death occu	rred at the time,	date and pl	ace, and due	to the cause(s)
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)
0		1.6	170			po	22206		it	107/200	
_	}	30. Name and address of person w		eath (Item	23a) (Type,						
8		ADRIAN MAU	NG Shoul -	TReun	s Gen	Print)  Rec. 225	s. Greene	Street	Baltin	nore, Mi	7 21201
Sta		31. Date filed (Month, Day, Year)	82. Registra	ar's Signat	ture	2		/			
Registr	ar	MOVIDZU	U AMERICAN	AND ASSESSED.	The same of the same						

			1 - For State Registrar		ate of N	Marylan		artmen rtificat			and M	ental Hy	/gien	200	7	3677	3
	Physici /Medi		1. Decedent's Name (First, Middle)									2. Date of D Month	eath Da	200)	/ear	3. Time of Death	
	Examir		4a. Facility Name (If not institution,			er)		_ '	-	Location o	f Death			. County of			
			DEFOR 17EDD	110 Y		10-450	fand bûdbeleed	If Under	12 BV	IrUnder 2	Jour F			mi co			
g <sub>a</sub>	Funeral Director		5. Social Security Number 218-20-8121  Usual Residence of Decedent	1 🔯 M			last birthday)	Months	Days	Hours	Min.	8. Date of Bi (Month, D Oct. 22	ay, $Year$	926	Vir	place (State or Foreintry) ginia	ign
	/land		10a. State 10b. County			10c. City	y, Town or Lo	ocation								10d. Inside City Limi	its
:	Mary a-1 sh	tor	MD Wicom	ico		Sa	alisb	urv								1 □ Yes 2 🔀	No
	death with the Maryland ms 23a or 28a-f show r must be notified ∎t	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of Wh	at Cou	ntry?	_
	ath w		28745 Ocean Ga						2180					SA			
0500-0	n /2 hours after death with the Marylan "natural", or items 23a or 28a-1 show balcal Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	ed 1	Vas Deceder Imed Forces ∑Yes 2 [ Yes, Give 'ear or Dates	s? □ <sup>No</sup> Wor14	d	Was Deced If Yes, spec 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	Americ White,	etc.	
2	72 ho	eted	15. Decedent' (Specify only highest	Education	n		16a. Dece	dent's Usua		ition furing most	of working	ng.	16b. F	Kind of Busi	ness/In	dustry	
7	d within giene. ir than "	Completed	Elementary/Secondary (0-12)	Ī	college (1-4o	or 5+)	life.	DO NOT u	se retired,	)	OI WOIKIII	'y	_				
А.			6th 17. Father's Name (First, Middle, L	ast)			La	abore	r	10 Mothor	ria Alama	(First, Middle		rnett		.te	
	0 12 12 0	Be c	Charlie B. Dix	asi)								Wise	a, Maidei	n Sumame)			
5	iges 1 and 2 should be it of Health and Mental : If item 27 is marked or or other traumatic ev	70	19a. Informant's Name/Relationsh	р (Туре, Р	Print)		19b. Mailir	na Address	(Street a			Route Numb	er. City	or Town. St	ate. Zir	Code)	_
= (	1 and 2. Health ar		Gerald Dix/Son										_			1 21801	
. עב	of Health of Health fitem 27 r other tr		20a. Method of Disposition	. 🗆		20b. P	lace of Dispo emetery, crei					ate		ocation - Ci			_
aitimor	rages nent of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		val from Stat	10	en Acres				Nov.	3, 2007	Sa1	isbur	у,	MD	
	permit. Page Department of Importent: If any injury or ance.		21. Signature of Funeral Service L	censee			22	2. Name an	d Addres	s of Facility	Sal	Lisbury,	Mary	yland			
4	20519	ii. I	Loulla &	1. /	elle	7						P.A 1		Jersey	Road	21801	
	hysician		23a. Part 1. Enter the disease, or or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one ca	use on each		n. Do not ent	er the mod	e of dying	g, such as o	cardiac or	respiratory a	arrest,		1	Approximate Interval Between Onset and Death	
	/Medical Examiner				Due to (or a	as a consequ		+ Fo	Luce						1	v frenc	
7		Iner	Sequentially list conditions, if any, leading to immediate cause. Errer Underlying Cause (Disease or injury	0		as a consequ		1 10	2010							2 1507	
9	and and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. <u>0</u>	)10(30)		ionno of									D TEDU	
, o	ician a		, and a second s		Due to (or a	is a consequ	Jence or):										
700	phys s the	edicai		d							- · · · · -						
Division of Manding Physician The June consistent and the death configuration of the June consistent with the death configuration of the June consistent with the death configuration of the June consistent with the physician of the June cons	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 4	yes, outcom □Live birth □Pregnant □Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pr Other (sp						23d. Date of Month		ery Day Year	
, T	igned by	þ	Part II. Other significant condition	s contribut	ting to death	but not resu	ilting in the ui	nderlying c	ause give	n in Part I.				use contrib		ne cause of death?	
S C	been si	eted	17 Bostownor	ر م			_										
	After this certificate has b tuneral director, page 2 s	Completed	Louisiting 1700c	LOIT	, to						_	24a. Was auto perf		dea	ere auto or to co ath? Yes	psy findings availab mpletion of cause of 21 No	ile f
V Ita	certif	Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{PNo} \)	Hospit	al: _				Othe			(Check only					_
5	ir this aral de	. To	27. Manner of Death		a. Date of In (Month, D		ER/Outpatien 28b. Time of		8c. Injury Work	4 Minur		ie 5 ☐ Res 8d. Describe				y)	_
	th. : Afte	ation	1 Matural 5 Pending 2 Accident investiga		(Month, D	Day Year)	Injury	М		? ′es 2 □ N	lo		·	•			
CIVIN 19	within 24 hours after death.  To the Funerel Director: After this certificate completely filled in by the funeral director, pag	Certification:	3 Suicide 6 Could no determin		e. Place of Ir building, e	njury - At ho etc. (Specify	me, farm, str	eet, factory	, office		2	8f. Location ( City or To			or Rura	ti Route Number,	
Po Hoori	within 24 hours after	edical	29a. Certifier 1 Certifying (Check only one)	kamıner; (	n: To the bes On the basis and manner s	of examinati	wiedge, death ion and/or inv	occurred vestigation,	at the tim in my op	e, date and inion, death	d place, a	nd due to the d at the time,	cause(s date an	and mann d place, and	er as s d due to	tated. the cause(s)	
F	Tor	Σ	29b. Signature and title of certifier	1.	0				. License				29d. Da	ate signed (	Month,	Day, Year)	
1	M .		Michael IV.	Hd	the 10	7		D	00	アノスプ	7		10-2	50-8			
H	IVA		30. Name and address of person w	ho complete		· ·	23a) (Type,	,	mpr	7 Lp-17	) 3	Y1301					
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 1	2007	32. P gis	trar's Signat	ure A	hard!	,								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** $31^{Day}$ 2007 Frances J. Doyle Oct. 10:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sun Valley Assisted Living Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct 28 | 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1904 Months Days 1 □ M 2 XF Director 580**-**05**-**7994 103 Kansás Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Directo MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? po q and 2 should be filed within 72 hours after death with 7 is marked other than "natura!", or Items 23a traumatic event, the Medical Examiner must b 1442 Buckhorn Rd. 21784 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No <u>6</u> Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker her home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Anthony George Frankenhoff Mary Christine Wolters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If item 27 is r or other trai 2040 Green Mill Rd finksburg, MD 21048 James Doyle IV -20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. S. Carroll Crematory 11/1/2007 Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servi Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximately Counce (1757) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia **Physician** 12 WS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: P 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c 28d. Describe how injury occurred Certification: Injury at Work? 5 Pending investigation or Attending Injury 1 w atural after death. 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

JL

State

31. Date filed (Month, Day,

DAN (

29b. Signature and title of certifie

32. Registrar's Signature

295

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

November 1, 2007

			State of Ma	ryland				and Menta	al Hyg	íene		
		1	= State Registrar		Cei	rtificate of L	Death	0.0	_	eg. No. 2	17	36775
	Physicia		I. Decedent's Name (First, Middle, Last)						ate of Deat onth	Day	Year	11:13 AM
	/Medic	al _	Rita F. Dayton  la. Facility Name (If not ignstitution, give street and number)			4b. City, Town, or	Location o	of Death	D	4c. County	007	11:13
	Examin	er '	Peninsula Kelionel Medica	100	dex	< //	URU	or Death			MIC	۵ ا
	Funeral			1 000	ast birthday)	If Under 1 Year	If Under	24 Hrs. 8. Da	ate of Birth	10.		place (State or Foreign
	Director		215-80-5439 1□M 2対F	45	Yrs.	Months Days	Hours	Min. 1/	fonth, Day, 9/196	2	Cour	MD MD
200	pt .	-	Jsual Residence of Decedent	100 City	, Town or Lo	cation					1	0d. Inside City Limits
	arylar show d at		I 0a. State 10b. County									1 ☐ Yes 2 🔀 No
	he Mi	Director	MD Wicomico  10e. Street and Number	PII	ttsvil	10f. Zip Code				0g. Citizen of	What Cour	ntry?
	with t		34594 Mt. Hermon Rd.			21850				USA		,
	leath	Funeral	11 Marital Status 12. Was Decedent E	ver in U.S	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Ori	igin? (Specify Y	es or No-	14. Ra	ce - Americ	
မွ	72 hours after death with the Maryland natural", or Items 23a or 28a-f show disal Examiner must be notified at		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ N  If Yes, Give	0		if Yes, specify Cuba 1 □ Yes 21K2 No	an, mexical Specify:		, etc.)		ck, White, fy: Whi	
Maryland 21215-0036	ural",	d by	3 ☐ Widowed 4  Divorced Year or Dates:				C/O.			16b. Kind of B		
5-(	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	st of working	T	16D. KING OFE	susiness/m	austry
121	withir ene. than	duc	Elementary/Secondary (0-12) College (1-4or 5-	+)	Coc	_	,			Conv	ience	Store
d 2	filed Hygi sther		17. Father's Name (First, Middle, Last)				18. Mothe	er's Name <i>(Firs</i>	t, Middle, i	Maiden Surna	me)	
an	ld be ental ked c	To Be	Gary West, Sr.				Ph	yllis M	elsor	ı		
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Street	and Numb	er or Rural Rou	ite Numbe	r, City or Town	, State, Zip	Code)
Ž	and 2 salth a salth a 127 is		Derek Dayton / son			ne St.,	Berli					
ore	of He fiter		20a. Method of Disposition 1 □ Burial 2XX remation 3 □ Removal from State	20b. Pl	lace of Dispo emetery, cre	osition (Name of matory or other plac	ce)	Date		20c. Location	- City or T	own, State
<u><u>Ĕ</u></u>	Pag ment ant: I ury o		4 □ Donation 5 □ Other (Specify)	Cap		open Cre		10/31/2		Frank		
Baltimore,	permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Linensee	1		2. Name and Addre			-	~		Iome
	ED = 8 0		23a. Part1 Inter the disease, or complications that caused	the death								Approximate
0.00			shock, or heart failure. List only one cause on each lin	ie.								Onset and Death
	Physician /Medical		disease or condition resulting in death)  Due to (or as			ER GA	3//~	CINTE	370	07722	HEEV	1)745
	Examiner			roonooqa	201100 0.7.							
	\$17	Je.	Sequentially list conditions, if any teading to limited accuse. Enter Underlying Cause (Disease or injury	t our secur	ianne offi						- 1	
	cuted nd ransit	Examiner	that initiated events c									
300	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	E	resulting in death) Last Due to (or as	1 consequ	uence of):							
53	cate t	dical	d									
-54 ox 68	certifi Iding	/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant	pf pregna	incy					23d. D	ate of deliv	very
SA	leath atter	Physician/Med	in the past 12 month  4☐Pregnant at			□Ectopic pregnanc: □ Other <i>(specify)</i> _	y 			N	lonth	Day Year
' 0	t the c by the achec	hysi	9 ☐ Unknown									
315 S, P.	res that the death certifica igned by the attending pl be detached for use as t	by P	Part II. Other significant conditions contributing to death be	ıt not resu	ulting in the u	ınderlying cause giv	en in Part	1.				the cause of death?
o gi	w require been sig should b								1 L Y	′es 2 No	3 🗆 Fro	bably 4 Dunknown
the Second	e law re has be je 2 sho	Completed						:	24a. Was a autop	an 24b	. Were aut	opsy findings available ompletion of cause of
200		E C							perior	rmed? 2 No	death? 1 ☐ Yes	2 □ No
Za Iita	ilcian: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?			Tout		e of Death (Ch	eck only o	ne)		
م لا	Physician: r this certific ral director,	은	1 Yes 2 No Hospital: 11 Inpatie		ER/Outpatie		4 LI N	lursing Home		lence 6 00		ify)
	Jing F	i,	1 I I ural 5 Pending (Month, Da		Injury	Wo	rk?  Yes 2.∐		Describe i	ion injury occi	21704	
X.ta ivision	Attending r death. ector: After by the fune	icat	3 Suicide 6 Could not be 28e. Place of init	ury - At ho	ome, farm, s	treet, factory, office		28f. L			nber or Ru	ral Route Number,
/×.ÿ	after after I Dire	Certification:	4 Homicide determined building, et	c. (Specify	y)			(	City or Ton	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier (Check only (Ch	of my kno	wledge, dea	th occurred at the ti	ime, date a	and place, and o	due to the	cause(s) and r	manner as	stated. to the cause(s)
	the Ho iin 24 the Fi	Medical	one) and manner sta	ited.		29c. Licens				29d. Date sign		
	To Con	2	29b. Signature and title of certifier	M	17			29/6	i	_		29,2007
			30. Name and address of person who completed cause of d	eath (Item	n 23a) (Type	Drint)						
	3A3		SUETRANA GUTTERNET	> ,	1415	SOUTH	910	15 con	SHITT	Z B SA	715A	URY 1917
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registr	ar's Signa	ature	V 1				· ·		21801
	Regist	rar	31. Date filed (Month, Day, Year)  NOV 0 2 2007  32. Registr	א נ	A)	eser .						

			For State Registrar	State of Maryl		epartment of H Certificate of L			giene 10g. Ng2 () () 7	36776
			Decedent's Name (First, Middle, La	st)				2. Date of Dea	ıth	3. Time of Death
	Physicia		Barbara Mae Did	irickson				October	Day Yes	
	/Medic Examin		4e. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
1			5997 Snow Hill	Road		Snow H:			Worces	
	Funeral		5. Social Security Number 6. S	DM 0875	yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, De)		Birthplece (State or Foreign Country)
	Director		215-14-7200 Usuel Residence of Decedent		85 Yrs			Dec. 9,	1921 M	aryland
	land	1	10a. State 10b. County	100	. City, Town o	r Location				10d. Inside City Limits
	Mary I et	ţ	MD Worces	ster S	Snow Hi	11				1 ☐ Yes 2X No
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a c	a la	5997 Snow Hill	Road		21863			U.S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show appringury or other traumatic event, i'm Medical Examinar must be notified at ODGe.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	mencan Indian, Thite, etc. white
Ö N	72 ho natur	Completed	15. Decedent's E (Specify only highest gr		(0	ecedent's Usual Occup Give kind of work done	during most of won	king	16b. Kind of Busine	ss/Industry
2	ithin sen	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retired			Dublic Ho	alth Service
2	led w tygier her th	S	17. Father's Name (First, Middle, Last	4	Reg	istered Nur			Maiden Sumame)	alth Service
Maryland	od of	Be c	Herman J. Ardis				Ella No		,	
2	should nd Me mark matic	2	19a. Informant's Name/Relationship		19b. N	failing Address (Street			er, City or Town, Stat	e, Zip Code)
	nd 2 s lith ar 27 le r trau		Kathleen Ardis		Law) 59	97 Snow Hi	11 Road	Snow Hi	11, MD 2	1863
ā,	S 1 ar	ı	20a. Method of Disposition	20	b. Place of D	isposition (Name of crematory or other place		Date	20c. Location - City	or Town, State
Ë	Page nert o nt: If		1XXBurial 2 ☐ Cremation 3 ☐  14 ☐ Donetion 5 ☐ Other (Speci			t Cemetery		3,2007	Snow Hil	1, Maryland
Baltimore,	permit. Departrimports eny inju		21. Signature of Funeral Service Lice	nsee		22. Name and Addresshort Fune 13 East Gr	ral Home	et Delm	ar, DE 1	9940
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	polications that caused the	death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ali	phla	stoma	- bra	in tu	mor	Onset and Death
	/Medical		resulting in death)	Due to (or as a cor						
	Examiner		Sequentially list conditions,	b						
	pe isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence or;					
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of	:		-		
8760,	sicien burig	dlcal E		d						
<b>68</b> 7		(a)		U						
.O. Box	The law requires thet the death certifi ate has been signed by the attending I page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	<i>'</i>		23d. Date of Month	delivery Day Year
<u>α</u>	uires thet signed by Id be deta	by	Part II. Other significant conditions	contributing to death but no	ot resulting in t	he underlying cause giv	ren in Part I.	23e. Did to	V	te to the cause of death?  Probably 4 Unknown
Vital Records,	ne law requir i has been s ge 2 should	Completed						24a. Was autop perfo	osy prior priped? deat	e autopsy findings available to completion of cause of h?
a		e Co	25. Was case referred to medical	1			26 Place of Dec	1 ☐ Yes ath (Check only o	2 No 1	Yes 2□ No
		To Be	examiner?	Hospital:	2 ☐ ER/Outp	eatient 3 DOA Oth		- 14		Specify)
on of	ling Alter une		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Tir	ne of 28c. Injur			how injury occurred	
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Alter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm	n, street, factory, office		28f. Location (: City or Tox		r Rural Route Number,
	e Hospite 24 hours e Funeral etely fille	edical C	29a. Certifier 1 Certifying P	hysicien: To the best of my miner: On the basis of exa and manner stated.	y knowledge, umination and/	death occurred at the til or investigation, in my o	me, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	M.A.	7	29c. Licens	se number	$\sim$	29d. Date signed (M	donth, Day, Year)
,			30. Name and address of person who	completed cause of death	(Item 33a) (T	ype, Print)	11-11	1110	0(01	0.1
	3A20		104 Ni	Bay Str	cet	Sum	MIII	w	4186	5
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 0 1	2007 /32. Registrar's S	o dignature	Sparke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day John Henry Eversull ctober 150 PM 2007 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Doctors Community Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Jan. 24, 1921 . Social Security Number 577-20-3940 7. Age (In yrs. last birthday) 86 Yrs. 9. Birthplace (State or Foreign 1 X M 2 □ F Iowa" Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 13119 Oriole Drive 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Airline Mechanic United Airlines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Eversull Mayme Barnett 19a. Informant's Name/Relationship (Type. Print)
Lois L. Eversull -wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 13119 Oriole Drive Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans Cemetery 11/1/2007 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 23a. Part1. Enter the disease, or convincations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Day 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | NO 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans Division or Vital Records, P.O. Box 68760, attending physician

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

r 28a-f show notified at

"natural", or items 23a or edical Examiner must be

in portant: If item 27 is marked other than "natu

permit. Pages 1 and 2 should be Department of Health and Mental

Director

Funeral

þ

Completed

Be

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

the for use detached ģ page 2 should certificate funeral director, 24 hours after death e Funeral Director:

Physician/Medical Examiner Be Completed by Certification: To

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

this

After t

the To the within

State Registrar Jan

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, **NOV 01** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #23b Per Phy G873 11/16/Pertificate of Death 36778 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Downes MATE FULLER 10 WPM NUN 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERUAL HOSP COLUMBIA HUWA-RUD Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 169-28-534 1 M 2 1 F PENNSYlvania -10-1933 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits HD LAUREL ¥ Yes 2 No HUWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20723 9105 BLUES ALLEY USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LETCHER BURGETTE CEDLA PARKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William FULLER JR. HUSBAND 9105 Blues Alley #1= LAUREL, 40 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1⊌ Burial 2 □ Cremation 3 □ Removal from State WASHINGOW, DC GLENUUUD CEMERSEY 11/14/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BIANCHI BIY UPSHUE ST NW DE JOUIT be, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AUTE RESPIRATIONLY Terminal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aspiration Chanco Pinaryn GEAL DYSPINACIA Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ZUDIMERS Dimentina 1 Yes 2 No 3 Probably 4 No Nown 24a. Was an

Physician /Medical **Examiner** 

the death certificate be executed

physician

been

has

certificate

this funeral

After t

the Funeral Director: Aff

the

2

the Hospital or Attending hin 24 hours after death.

Box 68760

P.0.

Records,

Division or Vital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or Items 23a or 28a-f sh edical Examiner must be notified

traumatic event, the Medical

d 2 should be filed within 7: th and Mental Hygiene. 7 Is marked other than "n

permit. Pages 1 and 2 sl Department of Health an Important: If item 27 Is r any Injury or other traur

Maryland 21215-0036

Baltimore,

Director

Funeral

Completed by

Be

ပ

Examine

Physician/Medical þ

as Completed Be

Certification: To

burial-tran the for use a ed by the a detached f signed b page 2 should director,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

autopsy performed Yes 2 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ⑤ Io

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

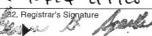
29d. Date signed (Month, Day, Year) 11/06/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) purish o which

10724 LITTLE PATUNDING PINNIN

State Registrar

31. Date filed (Month, Day, Year) NOV 1 6 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.? 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Johnny Gray 07 1005 M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Peninsula Regional Medical Center Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Funerai Months Days Hours 1**√** M 2□ F 221-16-1150 Director 78 2/28/1929 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 TYYes 2 □ No Director DE Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31244 Polly Branch Rd. 19975 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give 8-25-52 Year or Dates: 8-24-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Black ξ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M U.S. Post Office 3 Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Johnny Gray Sylvester Watson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Watson 31244 Polly Branch Rd. Selbyville, De et al Disposition (Name of Disposition (Name of Date 20c. Location - City or Gray 19975 20b. Place of Disposition (Name of cemetery, crematory or other place)
Delaware Veterans
Memorial Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 11-5-07 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Millsboro, Delaware 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen MOD268 22. Name and Address of Facility Millsboro, DE. Washington St. Watson Funeral Home 211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2010 certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 10 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 은 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ZEMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of carti 29d. Daje signed (Month, Day, Year) 1+5049) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 160 E. Carroll St. SAlisbury, Md. 21801 BA 10 hris Inyder

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 2 2007

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10 2007 Sherman Greer, Jr. 31 13:32 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Union Hospital Cecil 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours Min. 1 X M 2 □ F 238-58-1856 66 Director 11/2/1940 Lansing, NC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10b. County 10c. City, Town or Location 10d, Inside City Limits 10a. State PA Chester New Garden Township 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19374 917 Penn Green Road USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married Married 2**K** No 1 ☐ Yes 2 No Specify. Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking 9 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sherman - Greer, Sr. Ola - Greer 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nell Greer Box 57, Toughkenamon, PA 19374 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Carpenter Cemetery Lansing, NC 4 ☐ Donation 11/5/07 5 ☐ Other (Specify) 22. Name and Address of Facility 221-223 Pennsylvania Ave. 21. Signature of Fundral Service Li 19311 CC0442 de Cleveland & Grieco Funeral Home, Avondale, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Motastulic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed physician and sthe burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical use as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23h Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy for Month Year 5 Other (specify) signed by the at d be detached for 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has page 2 autopsy perform certificate 1∐ Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3□ DOA 1 ☐ Inpatient P this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

State Registrar

within 24 hours a

Medical

29a. Certifier

(Check only one)

29b. Signature and title

MARKHA

31. Date filed (Month Pay

30. Name and address of person who

Hosford

2007

Year)2

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

egistrar's Signatu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date/signed (Month, Dav. Year)

			For State Registrar	State of Marylar		irtment of He <i>tificate of D</i>		lental Hygi Re	ene g. n2 0 0 7	36782	
Physic			I. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death	
iv.	Physicia /Medic Examin	al -	MARTHA L. GREER		EER			OCT 31			
		er	4a. Facility Name (If not institution, give street and number)  CALVERT MANOR			4b. City, Town, or Location of Death  RISING SUN			4c. County of Death CECIL		
Control	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		. last birthday)	lf Under 1 Year   If Under 24 Hrs.   8		8. Date of Birth	9. Birthplace (State or Foreign		
В	Funeral Director			□M <b>¾</b> CXF 85	Yrs.	Months Days	Hours Min.	(Month, Day, NOV 18,		Country) ARYLAND	
	pu ,	Funeral Director	Usual Residence of Decedent  10a. State 10b. County	100.0	ity, Town or Lo	cation				10d. Inside City Limits	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at		MD CECIL	1.00.0	**	IG SUN				1 ∐Yes <b>2√∑</b> No	
			10e, Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
		al Di	1881 TELEGRAPH ROAD			21911			USA		
		ner	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Yes 2 ☒ No		J.S. 13.	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri		ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.	
36	s afte	by F.	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1		1 □ Yes 2 🔯 No	Specify:		Specify:	WHITE	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.	ed b							6b. Kind of Busines	ss/Industry	
215		To Be Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  [Give kind of work done during most of working life. DO NOT use retired)				ing				
				2		HOMEMAKER		(Eirot Middle N	HER HOME	<u> </u>	
and			17. Father's Name (First, Middle, Last)  GEORGE MULLIKIN  18. M					r's Name (First, Middle, Maiden Surname) RACE MASON			
Maryland			19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Mailir	ng Address (Street a			City or Town, State	e, Zip Code)	
Ma			ANNE G. YOUNGER -		5128	NEW KENT	ROAD, WI	LMINGTON	, DE 1980	08	
Jre,			20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place ELD CEMET	ERY NOV		20c. Location - City	or Town, State	
Ē	Pagement and: If		1 XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	) CH		and the second second	1 2007	,	CENTREVII	LE, MD	
Baltimore,	Departi Mport my inj		21. Signature of Funeral Service Licens	see	M	2. Name and Addres EALEY FUN	ERAL HOM				
R	Physician	Examiner	PO BOX 2866, WILMINGTON, DE 19805  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death								
10.3			Immediate Cause (Final	one captse on epoil line.	12/1	inson	100	16-67	60	Interval Between Onset and Death	
H	/Medical		disease or condition resulting in death)	a.  Due to (or as conse	equence f):	111301		15 34	J		
4	cate be executed  physician and the burial-transit		Sequentially list conditions,	b							
7			Sequentially list conditions, if a y, seeing to in the list cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	as a consequence of):						
<u>_</u>			that initiated events resulting in death) Last C. Due to (or as a consequ			of):					
68760,		dical	d								
89		w	IF FEMALE:								
The part of the pa								23d. Date of Month	23d. Date of delivery  Month Day Year		
P.O.	w requires that the death certif s been signed by the attending s should be detached for use a	ysic	1 ☐ Yes 2 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)								
		by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
rds											
Records,	aw as b	plet							24a. Was an autopsy autopsy findings available prior to completion of cause of death?  1  Yes 2 No 1 Yes 2 No		
<u> </u>	The ate h page	Completed									
Vital	Physician: The rithis certificate ral director, paq	Be	25. Was case referred medical examiner?  Hospital: 4 Dispital: 4 D								
ō	Phys r this ral dir	5 T	27. Maxler of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred								
ion	Attending Phradensister the ector: After this by the funeral	rtion	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No								
27. Mayner of beating investigation of the part of the								28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ital or irs after ral Di										
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To the within To the complete	Me	29b. Signature and title of certifier			29c. License	e number	2	9d. Date signed (M	lonth, Day, Year)	
			1 (slow	a Sin	/	hi> L	2005/1	147	10 3.	1/01	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLORIA SIMONSON, MD, 111 WEST HIGH STREET, SUITE 302, ELKTON, MD 21921											
	Sta Regist	ate NOV 2 2007 32. Registrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 6, 2007 **Physician** 11:27 A M Samuel Norwood Graves, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's 38730 New Market Turner Road Mechanicsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 78 1**X**]M 2□ F 218-24-6290 August 15, 1929 Maryland Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10b. County 10a. State 1 □Yes 2X No Mechanicsville St. Mary's Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 20659 USA 38730 New Market Turner Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ناه filed الانام filed الانام filed الانام الانام الانام الانام الانام الانام filed with State Department of Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer Correction permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event. 12 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Ruth Wright Samuel Graves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Irma Y. Graves / Wife 38730 New Market Turner Rd. Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition November 9, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial Gardens Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2007 22. Name and Address of Facility 21. Signatur of Funeral Service Licenses Mattingley-Gardiner Funeral Home, I P.O. Box 270 Leonardtown, MD 20650 nichail 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fibrosis Pulmovery Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nei Examir certificate be executed as the burial-transit and Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) ned by the a detached for P.O. 1 □Yes 2 □ No 9 Unknown signed by d 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Bilateral carotid \$ Ocelusion. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been signification of the case of Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 1 No 1☐ Yes Division or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 ☐ Homicide e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24

State Registrar

the

2

NOV 0 7 2007

29b. Signature and title of certifier



28227

N.K. Sayeraman MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DOO 313 44

29d. Date signed (Month, Day, Year)

11/6/07

Three Notch Rd Nechanicsville MD 2065

# Lorrative HPPKPUS Baltimore, Maryland 21215-0036

de	
760,	
687	
Вох	
.O.	
٥.	
ords	
3ecc	
tal	
Ţ	
0 0	
risic	
Ö	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 7 36784 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Doris Lorraine November 10 1:00 p.M Hipkins 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown Washington 7. Age (In yrs. last birthday)

11 Under 1 Year

12 Age (In yrs. last birthday)

13 Yrs.

14 Yrs.

15 Under 1 Year

16 Under 24 Hrs.

16 Under 24 Hrs.

17 Under 24 Hrs.

18 Date of Birth
(Month, Day, Year)

April 12, 1933 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 214-34-0516 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28e-f ehov other treumatic event, the Medical Examiner must be notified at 1√ Yes 2 No Directo Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Harp Place 21773 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married "natural", or 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Food Service Worker 12 Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grayson Franklin Rice Louise Frances Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other treum once. John W. Hipkins/husband 5 Harp Place, Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Mt. Zion United MethodistNov.13, 2007 Myersville, Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funda S. S. Licensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alknosdenofic Cardiovosculor disease **Physician** disease or condition resulting in death) IHOBEY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy requires that the death Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has the lirector, page 2 s autopsy performed? res 2/2 No 1 Yes 1 Yes 2 No Be 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA ဥ this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending within 24 hours effer death.

To the Funarel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D28365 11-11-07 lowser 30. Name and address of person who completed cause of death (Ithm 23a) (Type, Print) 1500 Pennsylvania Avenue MANZAR. Hagerstown, MD 21742 31. Date filed (Month, Day, Year)
NOV 1 6 2007 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08563 State of Maryland / Department of Health and Mental Hygiene 36785 Wendy Hawkins Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Month Day November 3, 2007 1. Decedent's Name (First, Middle,Last) 1846 hrs Physician/ HAWKINS MARIE Medic Examiner WENDY c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Rockville Shady Grove Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Davs Hours Min. Country) MD July 1,1963 46 M 2XF 220-80-8264 Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 10h. County 10a, State 1 X Yes 2 No Rockville MD Montgomery 23a or 28a-f show notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20850 330 Beall Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? death v Married 1 X Never Married 2 2 X No Black Yes Specify: Yes 2 X No specify: If Yes Give Year Divorced 3 Widowed 16b. Kind of Business/Industry hours after 16a. Decedent's Usual Occupation (Give kind of work done à 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Exar Completed Elementary/Secondary (0-12) College (1-4 or 5+) Brighton Gardens Nursing Assistant Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene. the Medical 12th 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) If item 27 is marked other 17. Father's Name (First, Middle, Last Frances Gaither Houston Prather traumatic event, Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 7904 Badenloch Way, Gaithersburg, MD 20879 S Vicki Smith (Sister) 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Baltimore, 1 X Burial 2 Cremation 3 Removal from State Sandy Spring, MD 11/17/07 or other Ash Memorial Cem Important 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Donation 5 Other Specify: igy ture of Funeral S 246 N. Washington St, Rockville, MD 20850 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval en Onset and Physician Death failure. List only one cause on each line edical Alcohol, cocaine and heroin intoxication Immediate Cause (Final disease .aminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED #ENDED 11,27,28a-f, perME, g873, 11/19/07 TT ysician burial 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760, Year IF FEMALE: Dav phy: Month 3 Ectopic pregnancy Fetal death 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 V Unknown i signed by the atte d be detached for u 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1. Yes 2 No 3 Probably 4 Unknown P.O. à Phencyclidine use 24b. Were autopsy findings available 24a. Was an Completed Records, prior to completion of cause of peen autopsy death? performed? No 1 🗸 Yes has ✓ Yes 2 No раде certificate 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Residence 6 Other4 Nursing Home 5 examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 this 28d. Describe how injury occurred 1 V Yes 28c. Injury at Work? ဥ 28b. Time of Injury 28a. Date of Injury After th 27. Manner of Death Certification: Yes 2 X No ıınk Natural n 24 hours after death.

Funeral Director: A
letely filled in by the fu Pending Fnd 5:38 pm Fnd 11/3/2007 28f. Location (Street and Number or Rural Route Number, City Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 Accident or Town, State) 6 X Could not be 3 Suicide 330 Beall Ave. Rockville. MD determined residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only within 2 To the

State Registrar

29b. Signature and title of certifier

-athe-

Tasha Greenberg MD.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 4, 2007

2007

30. Name and address of person who completed-eause of death (Item 23a)

and manner stated.

Assistant Medical Examiner

Findistrar's Signature

Mecel MP

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 11, **Physician** 2007 Harry Wesley Ketterman 7:45 PM M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mt. Airy Frederick Kline Hospice House 8. Date of Birth Jan. 25, 1938 7. Age (In yrs. last birthday) 69 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Maryland 218-30-7657 1**X** M 2 □ F **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a, State 10b. County Frederick 1XX es 2 □ No Maryland Frederick Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21701 100 East Fifth Street items 23a iner must b r death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or itel may Injury or other traumatic event, the Medical Examitoe once. 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auction Company Truck Driver 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Ford Harry A. Ketterman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio 13106 North Point Lane. Laurel. MD 20708 19a, Informant's Name/Relationship (Type, Print) Betty M. Rowe, sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery Nov. 16, 2007 20c. Location - City or Town, State 20a. Method of Disposition Warial 2 ☐ Cremation 3 ☐ Removal from State Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wae of Fun ral Service Licer Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cura 118705 /Medical er as consequence f Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: Tha law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3. Probably 4 □Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1□ Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice House Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 28b. Time of 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier (Check only one) or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 12, 2007 redent 140 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
46 BTHONES JOHNS DU DOWNET BTHONES Johnson 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2007

Registrar

DHMH 17 Rev 1/2001

State

Registrar

32. Regitrar's Signature

2007

State of Maryland / Department of Health and Mental Hygiene 2007Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** Hilda Lorraine Knoch 10:10 A. M 10 30 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Sykesville Copper Ridge 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 □ M 2 T Days Hours 217-26-1464 (Month, Day, Year) 11/01/1930 76 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏖 No Director Hampstead Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3830 Normandy Drive 3B United States 21074 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pre School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Blanche Widerman Newton B. Hetrick ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Blizzard - Daughter 20910 York Road Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Mem. Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/2/2007 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South M01490 Main Street, Hampstead, Maryland 21074 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 20 No 1 Yes/ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Yes 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w∞59993 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 295 32. Registrar's Signature 31. Date filed (Month, Day, 2007 NOV 0 1

DHMH 17 Rev 1/2001

Registrar

			Please I			partment of h		-	_	<b>-</b> -
		•	For State Registrar	0.0.0	-	ertificate of			Reg. No.	7 36789
	Dhyalair		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Ye	3. Time of Death
1	Physicia /Medic		Peter Paul Ko			1 2 =		Novembe		
	Examin	er	4a. Facility Name (If not institution, give s				or Location of Death		4c. County of E	
-	Tunnel		45553 Longfields B 5. Social Security Number 6. Sex		e (In yrs. last birthda	Great M  If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	St. Man	Birthplace (State or Foreign
п	Funeral Director		167-16-5843	M 2□F	86 Yrs.	Months Days	Hours Min.	(Month, Day	1921 Pe	nnsylvania
	pu ,		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits
	faryla shov ed at	or								1 ☐ Yes 2 X No
	the N 28a-1 notifi	rect	Maryland St. Mary 10e. Street and Number	S	Great Mi	10f. Zip Code			10g. Citizen of Wha	t Country?
	3a or	al Di	45553 Longfields I	Boulevard		20634			United S	States
	ems 2	iner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 1	3. Was Decedent of I	Hispanic Origin? (Sp can, Mexican, Puerto	ecify Yes or No Rican, etc.)		American Indian, Vhite, etc.
36	or Ite	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give	No	1 ☐ Yes 2 🛣 No			Specify:	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director	15. Decedent's Edu	Year or Dates:	16a. De	cedent's Usual Occu	pation		16b. Kind of Busine	White ess/Industry
15	nin 72 n "na Medic	plet	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or 5	` `life	ve kind of work done e. DO NOT use retire	during most of worked)	king		
212	d withi giene. er than	Com	12		· I	son Guard			Correcti	ons
pu	be filed ttal Hygi od other event, tt	Be	17. Father's Name (First, Middle, Last)						Maiden Surname)	
Maryland	should be find Mental I	은	Wasyl Koss 19a. Informant's Name/Relationship (Ty	rne Print)	19h M	ailing Address (Stree	Sophie W		<b>—</b>	te. Zin Code)
Ma	d 2 sho Ith and I		Jennie M. Koss/Wif							
	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of Di	sposition (Name of trematory or other pla	rus poure	Date G	20c. Location - City	s MD 20634 y or Town, State
Ë	Page nent o nt: If		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Cemetery	t .	4/2007	Philadelp	hia. PA
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other		21. Signature of Juneral Source Lizens			22. Name and Addr	and of Feetlers			Home, P.A.
8			Edward N. Brins	field, Jr	. M00052	22955 Ho1	1ywood Ro	ad, Leon	nardtown,	MD 20650 Approximate
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	ne cause on each li	i the death. Do not ne.	enter the mode of dy	ing, such as cardiad	or respiratory a	rrest,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a configuence of):	Conce			7	- cere
	Examiner			Due to (or as	a o con quence or):					
	Att	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	res that the death certificate be executed igned by the attending physician and be detached for use as the bunal-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C						
60,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
6876	cate b	dical		d						
9 X	certificate Iding phys	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date o	f delivery
Вох	death e atten ed for u	ciar	in the past 12 months?	4☐Pregnant a	2 ☐ Fetal death t time of death	3 □Ectopic pregnand 5 □ Other (specify) _	cy		Month	
P.0.	t the c by the ached	hysi	9 Unknown	9□Unknown						
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions co	ntributing to death b	ut not resulting in th	e underlying cause g	iven in Part I.			ite to the cause of death?
or Vital Records,	w require been si							''		Probably 4 □Unknown
ěč	aw S b	Completed				<del></del>		24a. Was auto	an 24b. Wer	re autopsy findings available ir to completion of cause of th?
a F	ate pag							1∐ Yes	2. No 1□	Yes 2⊠No
<b>X</b>		Be c	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outpa	tient 3 DOA Of	26. Place of Dea	,	one) idence 6 □Other (	(Specify)
ō	y Phys er this eral dii	. To	27. Manuar of Death	28a. Date of Inju	ary 28b. Tim	e of 28c. Inju			how injury occurred	
io	Attending Ir death. ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ny Year) Inju		Yes 2 No			
Division	r Atte er des irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of inj building, et	ury - At home, farm tc. (Specify)	street, factory, office	Э	28f. Location ( City or To	Street and Number ( wn, State)	or Rural Route Number,
	ospital or hours afte uneral Dir ily filled in			7.1. T. 0. 1	-flive-vilade a d	eath accurred at the	time data and also		equac(a) and mann	or as stated
	<b>I</b> 4 <b>F</b> 5	Medical	29a. Certifier 1  Certifying Phy (Check only one) 2 Medical Exam	iner: On the basis of and manner st	of examination and/o	eath occurred at the r investigation, in my	opinion, death occi	urred at the time	, date and place, and	d due to the cause(s)
MB	To the within 2 To the comple	Me	29b. Signature and tale of certifier	n-I	Pulat 1	29c. Licer	nse number		29d. Date rigner	Month, Day, Year)
			1 long	" "	new //		7710		11/1/0	
			30. Name and address of person who c	completed cause of o	death (Item 23a) (Ty	pe, Print)	ala 0000	1 Hall	mw I	ID 201021.
			30. Name and address of person who of David Federle	M.D., 6	405511	irec Not	CLI KACIC	1) 11011	July P	IN WUDO

State Registrar 31. Date filed (Month, Day, Year)
NOV 0 9 2007



	1 - State Registrar	( ant)		Cei	rtificate d	of Dea	ath	2. Date of Dea	leg. No. 2	107	36790		
ın	1. Decedent's Name (First, Middle, I ALLEN LEE	LANDIS						Month SEPTEME		2007	3. Time of Death  10:15 A.M		
al er	4a. Facility Name (If not institution, g	rive street and num			4b. City, Tow	n, or Loca BERL			4c. Count	by of Death			
	5. Social Security Number 6 235–70–3312	Sex 1 <b>XX</b> M 2□F	7. Age ( <i>In yr</i> s.		If Under 1 You Months Da		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	n r, Year)	9. Birthp	place (State or Foreign		
J.	Usual Residence of Decedent  10a. State 10b. County  MD ALLI	EGANY		y, Town or Lo						1	0d. Inside City Limits 1 XYes 2 □ No		
Director	10e. Street and Number				10f. Zip Co				10g. Citizen of What Country?				
runerai	333 FORT HILL A		dent Ever in U		Was Decedent If Yes, specify	of Hispani	ic Origin? (Sp	pecify Yes or No-		ice - Americ			
2	1 □ Never Married 2 💆 Married 3 □ Widowed 4 □ Div <i>o</i> rced		2 <b>X</b> No		1 ☐ Yes 2 💢		ecify:	Alcali, etc.)	Speci	ack, White, ify: WHI			
Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)	Education grade completed) College (1	-4or 5+)	(Give life, L	dent's Usual Oo kind of work do DO NOT use re	one during tired)		king	16b. Kind of E		•		
Be Con	17. Father's Name (First, Middle, La	st)		SALES	S REPRE	18. N	ne (First, Middle, I'TE MAY	INSURANCE  dle, Maiden Surname)					
0	JOHN KOELKER  19a. Informant's Name/Relationship	(Type. Print)			-	reet and N	umber or Ru	ral Route Numbe	r, City or Towr		,		
	ALICE LANDIS /	WIFE	loop F					E, CUMBE					
	20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		State	cemetery, crer	sition (Name of matory or other EMETERY	place)	1	8,2007	20c. Location	-	LLE, PA		
	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  UPCHURCH FUNERAL HOME, P.A.  202 GREENE STREET, CUMBERLAND, MD 21502												
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   Approximate Interval Between Onset and Death Cause (Final disease or condition as a cardiac or respiratory arrest, and Death Cause (Final disease).												
	resulting in death)  Due to (or as a consequence of):												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
I Examine	that initiated events resulting in death) Last	c Due to (	or as a conseq	uence of):									
ledica		d											
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	al death 3	⊒Ectopic pregn ☐ Other (specif					ate of delive lonth	ery Day Year		
by Ph	Part II. Other significant condition	s contributing to de	eath but not res	ulting in the u	nderlying cause	e given in F	Part I.				he cause of death?		
Completed								24a. Was a	120	Taken .	pably 4 □Unknown  ppsy findings available		
Comp		-						autop perfo 1⊡ Yes	sy rmetos 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of 2 No		
o Be	25. Was case referred to medical examiner?	Hospital:	noationt 2	EB/Outpation	* 3□ DOA	Other:		th (Check only o					
-	1   Yes 2   Month, Day Year)  1   Natural 5   Pending   Hospital: 1   Inpatient 2   ER/Outpatient 2					Injury at Work? 1  Yes		ome 5 Aesic 28d. Describe h			<u>y)</u>		
3 Suicide  3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Inc.)  City or Town, State)								ber or Rura	al Route Number,				
Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the backaminer: On the backaminer	best of my kno asis of examina ner stated.	owledge, death ation and/or in	h occurred at the	ne time, da my opinior	ate and place n, death occu	, and due to the irred at the time,	cause(s) and n	nanner as s e, and due to	stated. o the cause(s)		
Me	29b. Signature and title of certifier		A			cense num			29d. Date signed (Month, Day, Year)		**		
		1 h	my Ki		Do	033	280		09-	15-2	000		

State Registrar umberland, MD

30. Name and address of person who complete Tause of death (Item 23a) (Type, Print)

Sun Gunta MD. Gas Bont Ave., 30

31. Date filed (Month, Day, Year)

NOV 1 6 2007

NOV 1

09-15-2007

21502

			1 - For State Registrar	State of	f Marylar		artment of tificate o				giene Reg. No.	07	36791
	Dhusisi		1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio			Ronald I	Lee Loo	mis				Novembe		2007	1500 P <sup>M</sup>
7	Examir	er	4a. Facility Name (If not institution, give		,		4b. City, Town	, or Location	ol Death		4c. C	ounty of Dea	ith
			1136 Oldfield P				Elkte					Ceçil	
П	Funeral		5. Social Security Number 6. S	Sex IS∦M 2□F		. last birthday) Yrs.	If Under 1 Ye Months Day		r 24 Hrs. Min.	8. Date of Birt (Month, Day	v, Year)	C	thplace (State or Foreign ountry)
	Director		214-36-8609 Usual Residence of Decedent	Λ –	69					June 1	, 193	8 Ma	ryland
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Man	ō	Maryland Cecil		F	1kton							1 □Yes 2 No
	r 28g	ie	10e. Street and Number				10f. Zip Cod	9			10g. Citize	on of What C	ountry?
	th wit	by Funeral Director	1136 Oldfield P	oint Roa	ad		2192	1			Un	ited S	tates
	deal ms	ner	11. Marital Status	12. Was Dece	dent Ever in L	J.S. 13. \	Was Decedent of	f Hispanic Or	rigin? (Spe	cify Yes or No-		. Race - Am	erican Indian,
9	or its	正	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv			1 ☐ Yes 2 🔯 1			noan, etc./		Black, Whi pecify:	te, etc.
8	ural',	b Q	3 Widowed 4 Divorced	Year or Da	ites:						3		nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene other then "natural", or items 23a or 28a-1 ehow ent, the Medical Examirae must be notified at	Completed	15. Decedent's E (Specify only highest gr			(Give	lent's Usual Ock kind of work do: DO NOT use ret	ne durina mo:	st of workin	ng		d of Business	•
12	withir sne. then	F	Elementary/Secondary (0-12)	College (1	-4or 5+)			,				ıtomob	
7 7	Hygie ther int,		12 17. Father's Name (First, Middle, Last	)		Are	ea Manag		er's Name	(First, Middle,			turing
an	d be	Be c	Harry Lee Loomi									uao,	
Maryland	Should Mari	ပ	19a. Informant's Name/Relationship (			19b. Mailir	g Address (Stre			Thrift Route Numbe	r. City or 1	Town. State.	Zip Code)
Ž	nd 2 alth a 27 is r trau		Betty Loomis/Wi	fe			Oldfiel						
ē,	f Hei	10	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		D	ate		ation - City or	
E	Page Tent c Int; if		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		State Gi.	lpin Ma morial	natory or other p NOT	) 12	lovemt 2007	per 9,	F12+	on Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important; if item 27 is marked other then "natural", or items 23a or 28a-1 show way injury or other traumatic event, the Medical Examinat must be notified at Ance.		21. Signature of Funeral Service Lice	nsee	· · · · ·	22 U-	Name and Ad			1- D	A	.OII, TIE	rryrand
<u> </u>	80 E 8 8	1	Must. The	to Cin	mai		3 W. St	ockton	runer St.,	Elkton	n. MD	21921	L
			23a. Part 1. Enter the disease, or com shock, or heert failure. List only	plications that ca	aused the dea	th. Do not ent	er the mode of o	lying, such as	s cardiac or	r respiratory ar	rest,		Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	· Mot	astal	ic Co	lon Ca	W 000	-				Onset and Death
	/Medical Examiner		resulting in death)	Due to (	or as a consec								
	Lxammer	_	Sequentially list conditions,	b	7. (Const. Const.								
1	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (	or as a consec	quence of).							
か	and and Il-tran	xan	that initiated events resulting in death) Last	c	or as a consec	quence of):							
68760,	ficate be executed physician and s the burial-transit	aiE				40000 0.).							
687	ficate phys s the	edicai		_ d									
	certi nding use e	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregn	ancy					23	d. Date ol de	livery
P.O. Box	death e atte d for	icia	in the past 12 months?	4□Pregna	nth 2 ☐ Feta ant at time old		Ectopic pregna Other (specify)					Month	Day Year
o.	t the by the ache	hys	9 Unknown	9□ Unkno	wn								
	The law requires that the death certifite has been signed by the attending age 2 should be detached for use eares	by Physician/Me	Part II. Other significant conditions (	ontributing to de	ath but not res	sulting in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco use	contribute to	o the cause of death?
ğ	w require been sig should b									1 🗆 Y	es 2 🖃	No 3 □ P	robably 4 Unknown
သို	has be	Completed								24a. Was a		24b. Were a	utopsy lindings available
č	The ate has page	ĕ								autop perfor	med?	death?	completion of cause of
ā	ian: ntifica ctor,	Be	25. Was case referred to medical examiner?					26. Place	e of Death	(Check only or			
Ž	hysic his ce I dire	To	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Ir	npatient 2	ER/Outpatien	t 3□ DOA (	Other: 4 🗆 Ni	ursing Hom	ne 5 Resid	ence 6[	Other (Spe	ocify)
בַ	Attending Physician: or death. ector: After this certifics by the funeral director.		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	28c. Ir	jury at vork?	2	8d. Describe h	ow injury o	occurred	
s Si	teath tor: / the f	cati	2 Accident investigation 3 Suicide 6 Could not be			]		Yes 2					
Division of Vital Records,	lor At efter of Direct Jin by	Certification;	4 ☐ Homicide determined	28e. Place	of Injury - At h ig, etc. (Speci	iome, farm, stre fy)	et, factory, office	×e	2	8I. Location (S City or Tow		Number or R	ural Route Number,
_	To the Hospital or Atlanding Physician: The I within 2 hours elied death.  To the Euneral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 11 Certifying Pt	vsician: To the	hast of my ke	nwledge door	Occurred at the	time data -	nd place	nd due to the	nauco/c\ -	nd manners :	r etatad
	24 h 24 h Fur etely	edicai	(Check only 2 Medical Examone)	niner: On the ba	isis of examina	ation and/or inv	estigation, in m	y opinion, dea	ath occurre	d at the time, o	date and pl	lace, and due	e to the cause(s)
	To th withir To th somp	Me	29b. Signature and title of certifier	//	1		29c. Lice	nse number		i i	29d. Date s	signed (Mont	th, Day, Year)
			) /// He	ston	V		D	0035	65	- 3	11/	18/0,	7
	5		30. Name and address of person who	completed cause	death (Iter	m 23a) (Type,					(	/	
	C		Martha Hosford, M	.D., 111	W. Hi	gh St.	Suite	104, E	Elktor	n. MD	21921		
	Sta Registr		31. Date liled (Month, Day, Year) NOV 1 6 200	Ma C.	egistrar's Sign	nure	le le						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 24, 2007 2:15A. N George W. Loutsch /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 90 yrs. 8. Date of Birth (Month, Day, Year) 7 5. Social Security Number 471-07-3621 **Funeral** 1 XM 2 ☐ F Months Minnesota Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-4 show any injury or other treumatic event, the Medical Examinat must be notified at once. 1 ☐ Yes 2X No Maryland Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3112 Gracefield Road, #105 20904 United States Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 2 should be filled within 72 hours after on and Mental Hygiene. Is marked other than "natural", or Iter 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) United States Dept. of College (1-4or 5+5+ Elementary/Secondary (0-12) Asst. Director of Personnel Agriculture 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louise Kustrich George M. Loutsch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9704 24th Avenue Adelphi, Maryland 20783 Mary M. Hargrove -daughter 20a. Method of Disposition

1X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington National Cemetery 12/14/2007 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Concestive Heart Failure /Medical Due to (or as a consequence of): Examiner Arrhythmia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Renal Failure Due to (or as a consequence of): ed by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Chronic Obstructive Pulmonary Disease IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy 2 X No 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2X ER/Outpatient 3 DOA this 28c. Injury at Work? Phospitel or Attending Phospitel 24 hours after death.
Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 TYes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Fo the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ပ ္ဝ (tlesion up achelle D44156 10/25/07 30 Name and address of person who completed cause of death (Item 23a) Type Print) Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) State **NOV 01** 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician David Francis LINOWES October 29, 2007 2:10 P. M /Medical 4b. City, Town, or Location of Death Chevy Chase County of Death
Montgomery 4a. Facility Name (If not institution, give street and number) Examiner 5630 Wisconsin Ave. # 801 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8 Date of Birth **Funeral** Days Hours Marie Pay, 1 6ar) 1917 330-18-1992 **M**□M 2□F 90 New Jersey Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 X Yes 2 □ No MD Chevy Chase Director Montgomery the 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with annt of Health and Mental Hygiene.
In: I fitem 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be runy or other traumatic event, the Medical Examiner must be runy or other traumatic event, the Medical Examiner must be runy. 20815 5630 Wisconsin Ave. # 801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. MXYes 2 No If Yes, Give Year or DatesWW - II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Gollege (1-4or 5+) Elementary/Secondary (0-12) College / Education Professor 18. Mother's Name (First, Middle, Maiden Surname)
Rose Oglensky 17. Father's Name (First, Middle, Last, Be Joseph Linowitz ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Medfield, MA 02052 9 Heartstone Drive: Joanne Alinsky / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State Adas Israel Cong. Cem. Oct.31,2007 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Se 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsevand Death Immediate Cause (Final Vascular Dementia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): 10 Years **Examiner** Cerebrovascular Atherosclerotic Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 5 Years the Hospital or Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation and resulting in death) Last Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2√ No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No ဥ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident hours after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 10/31/07 29c. License number 29b. Signature and title of certifier 2 D 0043427 gue le 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 Irving Street, NW, Washington, DC 20010 M.D., Eric DeJonge, 31. Date filed (Month, Day, Year) egistrar's Signature State NOV 01 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 0 /Medical Tacility Name (If not institution, give street and number, 4c. County of Death Examiner od Ha NICOMICO If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) Months Days Min. Hours 1⊠M 2□F Director 213-30-1258 01/26/1933 MD Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County 28a-f show at "natural", or items 23a or 28a-f sl adical Examiner must be notified 1 ☐ Yes 2 No Director Ocean City MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important; or items 23a or: Important; filem 27 is marked other than "natural; or items 23a or: any houry or other traumatic event, the Medical Examiner must be not a the Indianal Examiner must be not any houry or other traumatic event, the Medical Examiner must be not any houry or other traumatic event, the Medical Examiner must be not approximate the provided of USA 21842 401 15th St. Unit 5 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ▼ Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. þ Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Social Security Admin. Program Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Adeline DiNardo ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Hurricane Rd., Ocean City, MD 21842 Marian Patti / cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frankford, DE 11/1/2007 Cape Henlopen Crem. 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service 108 William St., Berlin, MD 21811 1. Enter the disease, or complite ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 🗌 Yes 20 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy spital or Attending Physician: Thours after death, neral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 TYes 2 ER/Outpatient Certification: To Inpatient 27. Manner of eath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation (Month, Day Year) Injury Natural 2 Accident 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) BA 6+ aupl 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

NOV 0 2 2007

State of Maryland / Department of Health and Mental Hygiene 2007 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 10, 2007 **Physician** 1:35 a M Carlton Mills Lawrence Jr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner College View Center Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Feb 10, 1 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 X M 2 □ F 220-70-2753 49 1958 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Mary land Frederick Frederick 1 XYes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5610 Kirkland Drive 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Americen Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Food Service 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lawrence Carlton Mills Sr Eleanor Mae Fox 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Manahan, Sister 874 Mago Vista Road, Arnold, Maryland 21012 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Smithsburg Crematory Nov 13,2007 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 M00706 V Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumani /Medical le to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical use as IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 should be 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ector, page 1□ Yes 2□No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060417 Name end address of person who completed cause of death (Item 23a) (Type, Print) 6 Ohnson Shah 31. Date filed (Month, Day, Year) State 6 2007 Registrar

Box 68760 The law requires that the death certificate be Records, P.O. Division or Vital or Attending Physician: To the Hospital or within 24 hours aft To the Funeral Di

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

tal Hygiene.

Baltimore, Maryland 21215-0036

29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5530 Wisconsin Avenue, Suite 730, Chevy Chase, MD 20815 Allen A. Nimitz, MD

D07147

October 30, 2007

State Registrar

Medical

31. Date filed (Month, Day, Year) eğistrar's Signature 2007

After 1

after death.

20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner extown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 68 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F 343-30-7519 01/01/1939 Springfield, Ill Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at 1x Yes 2 □ No Queen Annes Director MD Chestertown death with the 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21620 USA 1600 Ewingtown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WW-II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2X Married 1 □ Yes 2 🕅 No 3altimore, Maryland 21215-0036 Specify: White Specify. ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Computer Supervisior Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Opal Kelly Earl Moore ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alice S. Moore ( Wife ) 1600 Ewington Rd Chestertown, Md 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐ Other (Specify) Howard Univ Med School 10/30/07 Washington, D C 22. Name and Address of Facilite 11ows, Helfen Bein & Newnan F. H. 21. Signature of Funeral Service Licenses 130 Speer Road Chestertown, Md 21620 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to miniorial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsecuence Examiner ig physician and as the burial-transit be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9∏Unknown 9 Unknown Part In Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ≥ 3 Probably 4 □Unknown 1□Yes 2□No Be Completed Im 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe ronu 645 certificate 2⊠ No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

the To the

> State Registrar

To the

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NOV 01

30. Name and address of person who completed cause

of death (Item, 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

ype	or	Print	in E	Black	Inde	elible	Ink	. Ens	sure	All	Cop	ies	Are	Leg
Stat	e o	f Mar	ylar	id / D	epar	tmen	t of I	-lealth	and	M b	ental	Hyg	giene	)

Please T ible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month  $\mathbf{A}^{\mathsf{M}}$ **NOVEMBER 2** 2007 6:50 WILLIAM JOSEPH MIKSA 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1**X**M 2□ F Months JANUARY 14, 1936 MARYLAND 216-32-0731 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 📆 No MARYLAND QUEEN ANNE'S **STEVENSVILLE** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 600 BAYSIDE DRIVE 21666 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1958—1960 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) MANAGER **GROCERY STORES** 11 anould be filk ofth and Mental Hyan 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev THOMAS MIKSA CATHERINE FITZPATRICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 BAYSIDE DRIVE, STEVENSVILLE, MARYLAND 21666 JOANNE MIKSA/WIFE 20b. Place of Disposition (Name of Commetery, crematory or other place)
HOLY REDEEMER 20c. Location - City or Town, State 20a. Method of Disposition NOVEMBER 6 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 2007 BALTIMORE, MARYLAND CEMETERY 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Inter 1. dis ...e, or complica ...s II. t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. Ture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** cardiamyopath Schemic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a light conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4. □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 completely filled in by the funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MT 58510

State Registrar

phen <sup>Year)</sup> 2 32. Figistrar's Signature 31. Date filed (I 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001 MEDICAL PARKWAY, ANNAPOLIS, MD 21401

State of Maryland / Department of Health and Mental Hygiene 36799 Reg. N2 0 0 7 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James Francis McKernan October 30, 2007 4:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**™** M 2□ F Yrs. 89 067-09-9388 Apr 27, 1918 **Director** Ireland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 Yes 2 No Westminster Carroll Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 21158 Ireland 402 Cobbs Choice Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white \$ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Buses Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Kate Feeney James Joseph McKernan ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. 402 Cobbs Choice Lane, Westminster, MD 21158 Gail Buss, daughter 20b. Place of Disposition (Name of Scorptely, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Crematory 11/01/2007 Winfield, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home intar 91 Willis Street, Westminster, MD 21157 23a Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Shock Hypovolemic /Medical Due to (or as a consequence of): Examiner hemorrhage Gastrointestinal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ dilated cardioniyopathy 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🐧 No autopsy performed? Yes 2 A No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 💢 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖪 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 ABDALIAH J. HELOU, M.D. CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 31. Date filed (Month, Day, Year) State NOV 0 2 2007 Registrar

Box 68760. P.O. Division or Vital Records,

To the Hospital or Attending Ph within 24 hours after death.

\* To the Funeral Director: After th completely filled in by the funeral WIL DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Registrar

29b. Signature and title of certifie

P. Heno

29a. Certifier (Check only one)

> erron S. MD 2973 Manchester Rd 32. Registrar's Signature NOV 0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10051924

29d. Date signed (Month, Day, Year)

Manhayer

0dolor 30,2007

State of Maryland / Department of Health and Mental Hygiene 36801 Certificate of Death Reg. No. [] 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Vear 11:11 P M 5, 2007 Lawrence Eugene Payne November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 26125 Budds Creek Road Chaptico St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Director 65 01/24/1942 220-38-4125 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical =xaminer must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26125 Budds Creek Road 20621 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No <u>S</u> Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 10 Brick Layer Masonry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Earl Burton Doris Virginia Payne 2 of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorie Burch / Daughter 26110 Cresent Lane Mechanicsville, Maryland 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Brinsfield-Echols Cre 11/7/2007 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARCINOMA OF UNINARY BLADDER disease or condition resulting in death) 3 YKARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to or as a consequence of The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Tes 임 2 ER/Outpatient 3 DOA 27. Manner of eath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours af the Funeral D mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier ca (Check only within 24 | To the Fu one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20014/68 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) Robert J. Bauer, 28103 Three Notch Rd., Ste 101 Mechanicsville, Md. 20659 31. Date filed (Month, Day, Year) NOV 0.8 2007 Registrar

		-
D /=D8/33	7_08731	n

7-08731			e or Print in B						ble.			
orothy Edna Pi		St. I-ForState	ate of Maryland	•			Mental Hy	giene	200	7 3680		
		Registrar		Centi	ficate of	Death		Reg	. No. 200	3. Time of Death		
Physicia Medical Exami		Decedent's Name (First, Middl						2. Date of Death Month I November 1	Day Year	0905 hrs		
R		Dorothy Ed  4a. Facility Name (if not institution			17	4b. City, Town, or Lo	ocation of Death	November	4c. County of Deati			
		410 Edlon Pk	on, give street and number	,		Cambridge	oation of beating		Dorchester			
Funeral	=	Social Security Number	6. Sex 7. A	ge (In yrs. last	t birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9. Bir	thplace (State or		
Funeral Director						Months Days	Hours Min.		Forei	gn		
	-	219-22-8472 Usual Residence of Decedent	1 M 2 X F	80	Yrs	•		July 25	, 1927	ountry) MD		
any	l	10a. State 10b. County		10c. City, To	own or Locati	ion				10d. Inside City Limits		
ž "		MD Doro	chester			Cam	bridge			1 X Yes 2 No		
aryland 8a-f show at once.	윉	10e. Street and Number				10f. Zip Code		100	g. Citizen of What Cou	intry?		
he Me Milled	Director	410 Edlon Pa	ark			216	13		USA			
MCCC feer the Maryland I", or items 23a or 28a-f sho		11. Marital Status	12. Was Deceder	nt Ever in U.S.		as Decedent of Hispa				rican Indian, Black,		
Z the least	Funeral	1 Never Married 2 M	Armed Forces	? 2 X No	If Y	es, specify Cuban, I	Mexican, Puerto I	Rican, etc.)	White, etc.			
	by Fi	3 X Widowed 4 Div	vorced If Yes, Give Year	<u> </u>	1	Yes 21X No	specify:		Specify: Wh	ite		
2 hours af "natural LExamin		15. Decedent's Education (Spe		mpleted) 1		nt's Usual Occupatio			16b. Kind of Business	/Industry		
6 72 h 72 h cal E	Completed	Elementary/Secondary (0-12)	College (1-4 o	5+)	duning	•		) 	own home			
orthin enc.	티	11				homemak						
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hygiene. dother than "natural", or items 23a or 28a-f shot, the Medical Examiner must be notified at once		17. Father's Name (First, Middle				18		(First, Middle, M routsak	aiden Surname)			
be be	o Be	Henry W. Le			10b Mailin	a Address (Street			per, City or Town, Stat	e Zin Code)		
e, MD 21215-0036  1 and 2 should be filed within 72 Health and Mental Hygiene. item 27 is marked other than	۲	R. Michael Do		son					ington, DO			
and 2 lealth tem 2		20a. Method of Disposition				sition (Name of ceme		Date	20c. Location - City of			
Baltimore, permit. Pages I a Department of He Important: If ite		1 X Burial 2 Cremation	n 3 Removal from S	olate	ematory or ot			. (4.5./05	a) ) a	1 100		
tir. Pa		4 Donation 5 Other S		lold	Trini	ty Church	T- 100		Church Cr			
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Mt Important: If them 27 is ms injury or other traumatic er			Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home 7700 Locust St., Cambridge, MD 21613 a. Part , Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart									
Physician		23a. Part Enter the disease, or	r complications that cause	d the death. [	Do not enter t	the mode of dying, s	uch as cardiac or	r respiratory arre	st, shock, or heart	Approximate Interval		
) /Medical		failure. List only one cause	e on each line.							Between Onset and Death		
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor	sequence of):								
		Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	sequence of):								
	ш	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of):								
iox 68760, eath certificate be executed a attending physician and for use as the burial - transit		,	d									
e exectian a	lical	X UNPENDED	4MENDED 2	8a-f.ner	ME. C874	, 12/6/07 T	Т					
760 cate b physi he bu	Me	IF FEMALE:	23c. If yes, outo						23d. Date of delive	•		
68 certifi	ian/	23b. Was decedent pregnant in t past 12 months?	I I TIVE DITUIT	at time of dea	~ =	etal death 3	Ectopic pregna	ancy	Month	Day Year		
OX leath of for us	Physician/Med	1 Yes 2 V No 9 Un	nknown 9 Unknown	at time of dea	<sup>tn</sup> 5	ther (Specify)			ì			
O. B trthe de by the		Part II. Other significant condi	itions contributing to de	ath but not res	sulting in the	underlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute t	o the cause of death?		
cords, P.O.   law requires that the has been signed by the e 2 should be detache	Completed by							1 Yes	2 🗸 No 3 🗌 Pr	obably 4 Unknown		
ds, requir	etec							24a. Was a		autopsy findings available completion of cause of		
COI s law s has l	ם							autops	med? death?			
tal Recian: The certificate		25. Was case referred to medical	01			26 Place	of Death (Check	1 Yes 2	2 No 1 🗸	Yes 2 No		
ital sician s cert irecto	Be	examiner?	Managhala man	tient 2 .	ER/Outpatien		Nibor -		Residence 6 🗸 Oth	er: Scene		
of Vital Bing Physician: After this certifi	은	1 Yes 2 No 27. Manner of Death	28a. Date of I (Month, Da		28b. Time of		at Work?	28d. Describe h	low injury occurred			
on Control of the Con	iö	1 Natural 5 Pen	and the second s	10/2007	End O.O	1 Y	es 2 X No	subject d	rowned self	in bathtub		
riSic r Atte er dea irecto	fica		28e Place of	The second secon		eet, factory, office bu	uilding, etc.			Rural Route Number, City		
Div ital or ral Di	Certification:		ermined (Specify)	ther-sc	cene			or Town, S 410 Edlo	n Pk, Cambri	dge, MD		
Hosp 24 hou Fune rely fil		29a. Certifier 1 Certifying F	Physician: To the best of	my knowledge	e, death occu	urred at the time, dat	te and place, and	due to the cause	e(s) and manner as st	ated.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Exa	aminer:On the basis of e	kamination an	d/or investiga	ation, in my opinion,	death occurred a	at the time, date a	and place, and due to	the cause(s)		
F > F 8	ğ	29b. Signature and title of certific		1		29c. License	number		29d. Date signed (A	fonth, Day, Year)		
		abyl	MI	1		O.C.N	И.E.		November 11,	2007		
		30. Name and address of person										
	1 /	Zabiullah Ali, M.D.	Assistant Medical	Examiner	111 Per	nn Street, Baltii	more, MD 21	201				

State 31. Date filed (Month Opy, Year) 3 2007 32. To distrar's Signature, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08677 State of Maryland / Department of Health and Mental Hygiene James Starling Price 2007 36803 Certificate of Death 1- For State Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day November 8, 2007 0752 hrs Medical Examiner James Starling Price 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 9813 Bethesda Church Road #103 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (in yrs, last birthday) if Under 1 Year 6 Sex 5. Social Security Number **Funeral** Foreign Days Hours Min Months Country) Maryland Director 1 X M 2 F May 8, 1966 41 216-80-5535 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Ę Yes 2 X No 28a-f show Westminister Maryland Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number must be notified at 3605 Turkeyfoot Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: White 3 Widowed 4 X Divorced If Yes, Give Year event, the Medical Examiner "natural". \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. MD 21215-0036 Attendant/Manager Gas Station marked other 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brenda Lynn Seabolt James Albert Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) of Health and N 3605 Turkeyfoot Road, Westminister, MD Brenda Grady, mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Forest Oak Cemetery 11/13/2007 Westminister, Maryland Donation 5 Other Specify 22. Name and Address of Facility Molesworth-Williams Funeral Home 21. Signature of Funeral Service Licensee Maryland Ridge Road, Damascus. Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failur. Li conly one cause on each line. Death /Medical a Mixed drug (cocaine, oxycodone, porphine) intoxication Immediate Cause (Final disease or condition resulting in death) tamine Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause Enter underlying cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED tending physician a use as the burial -^\#\frac{1}{2}34,27,28a-f, perME,g873, \frac{11}{19}\text{07 TT} Box 68760 23d, Date of deliver 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) No 9 Unknown Yes 2 a Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ó 1 Yes 2 No 3 Probably 4 V Unknown <u></u> ۵. Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? has nerformed? 1 🗸 Yes certificate h ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medica Be Other<sub>4</sub> examiner? Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient 2 ER/Outpatient 3 this 2 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) After 27, Manner of Death Certification: Natural Yes 2 X No Fnd 11/8/2007 Fnd 7:45 am 2 28f. Location (Street and Number or Rural Route Number, City

To the Hospital or Attending Physician: Division of Vital 24 hours after death.

Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide determined residence Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) November 8, 2007

Church Rd. Damascus. M

or Town, State) 9813 Bethesda

30. Name and address of person who completed cause of death (Item 23a)

2007

Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

Registrar

Medical

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** ERNICE ROTHE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death ity. Town, or Location of Death Examiner 7 WHITAKER 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Numbe **Funeral** Month Year 1□ M 2 F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limit 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced ShiTE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Be DENSIL 19a Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIELANG 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 5 Other (Specify) RDENT CREMATORY 4 Donation HANDVER, MD. 11-18-07 22. Name and Addre 21. Signa s of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Approximate Interval Between Onset and Death Enter the disease that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. ause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it is a sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 V Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ို 2**℃** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are
To the Funeral Di 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) .UC 39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
NOV 1 6 2007

State Registrar

DHMH 17 Rev 1/2001

Registrar's Sig

07-08756 Susan Marie Rodak

Medical Examiner

Physician/

1- For State Registrar

Decedent's Name (First, Middle,Last)

Susan Marie Rodak

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leg

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

s <b>Are Legible</b> giene	2	0 0	7	3680	16
Reg. No.					-
2. Date of Death Month Day November 11,	Year 2007		103	of Death 0 hrs	
1	: County of Anne Aru	ındel			
8. Date of Birth (MM	/DD/YYYY)	9. Bir Foreig	thplace (	State or	1
May 3, 1	961			<u>irginia</u>	l l
			10d. In	side City Limits	4
				Yes 2 X No	
10g. Ci	tizen of Wh	at Cou	ntry?		7
		SA			
pecify Yes or No- Rican, etc.)		- Ame e, etc.	rican Ind	ian, Black,	
	Specify:	Wh:	ite		- [
work done 16b	Kind of Bu	siness	/Industry		
	.s. N	ava	1 /	AAMC	
cal iptionist					
e (First, Middle, Maide	n Surname	)			
a Ann Tisc	her				_
Rural Route Number,					
e Ct. Ar	napol	is,	MD	21409	
Date 20	c. Location	- City	or Town,	State	
v. 13, 200 <u>7</u>	Balti	moi	e, l	MD	
.A. Sever	ma Pa	ark	Fune	eral Ho	me

29d. Date signed (Month, Day, Year)

November 12, 2007

2		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death  Anne Arundel
		17 Gypress Greek Road 17 Cymress Greek Road	Severna Park	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Manual David Hours Min	MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		267-73-1281 1_M 2\overline{X}F 46	Yrs. Months Days Hours Will. May 3,	1961 Country) Virginia
		Usual Residence of Decedent  10c. City, Town or Lo	nation	10d. Inside City Limits
, any	l	Tob. County		1 Yes 2 X No
Maryland 28a-f show	5	MD Anne Arundel Annapol	10f. Zip Code 10g.	Citizen of What Country?
daryli 1ato	Director	10e. Street and Number	21409	USA
U DD ith the Maryland 23a or 28a-f sho			Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
h with	era era	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
r deat or ite	Funeral	1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year 1 983 – 1 989	Yes 2X No specify:	Specify: White
s afte rraf",		3 Wildowed 4 Divolced or Dates: 1983-1989	edent's Usual Occupation (Give kind of work done	6b. Kind of Business/Industry
hour "natu	pleted	Flementary/Secondary (0-12) College (1-4 or 5+)		U.S. Naval / AAMC
36 hin 72 than than	1 9	Nav Music	y / Medical cian Transcriptionist	
5-0036 ed within 72 tygiene. other than	9	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Ma	
215-0036 be filed within 7 mal Hygiene. rked other than	9	Lewis Everette Wilson	Anita Ann Tis	er City or Town State Zip Code)
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiente frem 71's nameked other than "natural", or items 23a or 28a-f she frammair event, the Medical Examiner must be notified at once	Ę	19a. Informant's Name/Relationship (Type, Print )		Annapolis, MD 21409
MD nd 2 sho alth and m 27 is		banes 2. (tedas)	sposition (Name of cemetery, Date	20c. Location - City or Town, State
s l an f Hea		4 Rurial 2 X Cremation 3 Removal from State crematory of	or other place) Nov. 13,	Baltimore, MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. This firem 27 is marked other than "natural". This or other transative result, the Medical Examinar.		Metro	o Crematory 2007	
Salti epartr nport		21. Signature of Funeral Seption Licens, e	22. Name and Address of Facility Barranco & Sons, P.A. Seve 195 Gov. Ritchie Hwy. Seve	erna Park Funeral Home
	_	2. Pa I. Enter the disease, or a molications that caused the death. Do not en	nter the mode of dying, such as cardiac or respiratory arres	st, shock, or heart Approximate Interval Between Onset and
Physicia Media		fail ire. List only one cause or years line.		
xamine		Immediate Cause (Final disease a. Mixed drug (CITALO; Tolling) or midition resulting in death)  Due to (or as a consequence of):	, zoipdem, and quetiapine) intoxic	
	Г	D		
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	١	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying Cause (Disease or injury that initiated events resulting in death) Last Underlying C		
of d	ansit			
Box 68760, ne death certificate be executed the attending physician and the attending	a - 1	X UNPENDED  X AMENDED  #4a, 23a, 27, 28a-f, permulation permulati	rME.0873. 11/27/07 TT	
60, ate be	e bun	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery  Month Day Year
Box 68760, death certificate be the attending physic	e as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy  Other (Specify)	
ox o	for use as	J 1 Yes 2 No 9 ✓ Unknown g Unknown		
the de	<u>8</u>	Part II. Other significant conditions contributing to death but not resulting in	If the dilderlying coose given in the artis	bacco use contribute to the cause of death?
Records, P.O. The law requires that the case that the case has been signed by	e deta	<u>a</u>	1 Yes	2 No 3 Probably 4 Unknown
ds, equire	d blue		24a. Was a autop	sy prior to completion of cause of
COT law re has b	2 sho	Completed	perfor	
Re The ficate	, pag	Ö ar W	26.Place of Death (Check only one)	
ital ician: s certi	rector	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outp	patient 3 DOA	Residence 6 Other: Scene
Phys er thi	eral di	1 Yes 2 No 28a. Date of Injury 28b. Tir		how injury occurred
nding th.	e fun	1 Natural 5 Pending Fnd 11/11/2007 Fnd		ingested drugs
Division of Vital Records, P.O tall or Attending Physician: The law requires that I safer death.  al Director: After this certificate has been signed b	by th	2 Accident Investigation 28e. Place of Injury - At home, farm	m, street, factory, office building, etc. 28f. Location (	Street and Number or Rural Route Number, City State)
Division of Vital Records, P.O. he Hospital or Attending Physician: The law requires that it in 24 hours after death.	lled in	determined (Specify) street (in	car) 17 Cypres	ss Creek Rd. Severna Park, Pl
Hospi 24 hou	tely fi	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	b accurred at the time, date and place, and due to the caus	se(s) and manner as stated.
lie I the I	nplei	(Check only one) 2 Medical Examiner: On the best of my knowledge, dealing one) 2 Medical Examiner: On the best of my knowledge, dealing one) 2 Medical Examiner: On the best of my knowledge, dealing one)	estigation, in my opinion, death occurred at the time, date	

Jack Titus MD.

30. Name and address of person y

29b. Signature and title of certifie

o completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

			For	Please	Type or State o	<b>Print in</b> f Maryla							-		_	ble.		
			1 - State Registrar						ificate					Reg. N		07	36	807
	Physici		1. Decedent's Name		st) n Florer	nce Roo	dgers						2. Date of I Month Octob	D	ay 27,	Year 2007	3. Tim	e of Death
1	/Medic Examir		4a. Facility Name (If				.,,,,,		4b. City, To	own, or	Location	of Death	00000		c. County		1	
				rd Memor:							le Gr					Harf		
Ь	Funeral		5. Social Security No. 216-44-5		Sex I□M 2√2 F	7. Age (In yi 61		,	If Under 1	Year Days	If Under Hours	Min.	8. Date of 8 (Month, I	Day, Yea				ite or Foreign
	Director		Usual Residence of					J					Aug. 2	28, 1	1946	Iv.	laryla	and
	nyland how		10a. State	10b. County		10c.	City, Town o	or Loca	ation								10d. Insid	e City Limits
	8a-1 e	Director	Maryland	Cec	il 				Per	ryv:	ille						1 🔯 🔾	res 2 □ No
	with the	Dire	10e. Street and Num	ord Dri	V7.0				10f. Zip C		21903	2		10g. C	itizen of V			
	ne 23	erai	11. Marital Status	COLG DII	12. Was Dece	edent Ever in	U.S.	13. Wa	as Deceder				cify Yes or I	No-	14. Rac	U.S	· A ·	1.
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow spirightry or other traumatic event. The Madical Examinar rolls is notified at page.	by Funeral	1 Never Marrie		Armed For 1 Yes If Yes, Given Year or D	orces? 2 <b>[X</b> ] No ve			Yes, specify □ Yes 212				ecify Yes or t Rican, etc.)			ck, White		
Š	2 hou	ted		15. Decedent's E	ducation		16a. D	ecede	int's Usual (	Occupa	tion			16b.	Kind of Bu			
215	thin 7	Completed	(Speci Elementary/Secon	fy only highest grandary (0-12)	ade completed) College (1	1-4or 5+)		Give kii ife. DC	ind of work O NOT use	done du retired)	u <i>ring m</i> os	st of worki	ng					
2	led will ygien her th	Con	47 F-M- d- N /	Since Address / new	Two Ye	ears			Home								Resid	lence
anc	d be fi	Be	17. Father's Name (	Joseph I		ıka					18. Moth	er's Name	(First, Midd Hatti			18)		
Maryland 21215-0036	should nd Me mark imath	ဥ	19a. Informant's Na	me/Relationship (	Type, Print)		19b. N	Mailing	Address (S	Street a	nd Numbi	er or Rura	I Route Num			State, Z	ip Code)	
Š	elth a 27 Is		Woodrow	W. Rodge	rs (sor	n)		_					len Bu					21060
ore,	ot Heror fitem		20a. Method of Disp	osition Cremation 3	Demount from	20b	. Place of D cemetery,						ate	-		-	own, State	Э
Baltimore,	Pag ment lant: I		4 Donation	5 Other (Specif	(y)	R.	A. Fer	ris	& Co.,	Inc	• 🚽	11/2	2/07	Wes	t Ches	ster,	Penns	ylvania
Ball	Depart Import eny in		21. Signature of Fur	neral Service Licer	nsee	00.0	. <	Lee	Name and A	att	erso	n & S	Son Fu	nerai	l Hon	ne, I	P.A.	
	442		23a. Part 1. Enter th	e disease or com	nlications that o	aused the de		Per	ryvil	le,	Mar	yland	219	03 <u>-0</u>	766		Approxi	mate
	Dhusisian		snock, or near Immediate Cause (I	ttallure. Listonly Final	one cause on e	ach line.								anest,			Interval Onset a	Between nd Death
	Physician /Medical		disease or condition resulting in death)	-	a. Due to	Nyoca (or as a cons	equence ol)	ca 1	1 4	noc	W C	100					36	minuTe
	Examiner		Sequentially list con	ditions	b													
7	sit ad	iner	Sequentially list confiany, leading to implicate. Enter Under Cause (Disease or i	mediate tying		(or as a cons	equence oi)	:										
	be executed siclen and burial-transit	Examin	that initiated events resulting in death) L		c. Due to (	or as a cons	equence of)						-			_		
760,	e be e) siclen																	
687	certificate t Iding physic	Physician/Medical	d.															
Вох	eath cert attending for use	an/N	IF FEMALE: 23b. Was decedent		23c. If yes, out	come of preg		3 □E	ctopic preg	nancv					23d. Date of delivery  Month Day			
0	0 0 0	/sici	in the past 12 r 1 ☐ Yes 2 ☒ 9 ☐ Unknown		4□Pregn 9□ Unkno	ant at time of	death		Other (speci						МО	ntn	Day	Year
٦.	The law requires that the te has been signed by th rage 2 should be detache		Part II. Other signifi	cant conditions of	contributing to de	eath but not n	esulting in th	ne und	lerlying cau:	se givei	n in Part I		23e. Did	tobacce	use cont	ribute to	the cause	of death?
Vital Records,	quires n sign ald be	d by	9	/					, •	J					2 🗆 No			□Unknown
O O	aw requir s been si 2 should I	Completed	Di	abetes	Meli	litus							24a. Wa		24b. \	Were aut	opsy findir	ngs available
ž	: The law cate has I	mo.												opsy formed? 2 □ N		death?	ompletion 22/10	of cause of
ıta	ician: Th certificate rector, pag	Bec	25. Was case referre	ed to medical		/					26. Place	of Death	Check only					
	Attending Physician: r death. ector: Atter this certific by the funeral director.	2	1 ☐ Yes 2 🗗				□ ER/Outpa		3□ DOA	Other	4 140	-	ne 5 □ Re				ify)	
UQ O	ding P. Atter funer	ton:	27. Manner of Death	5 Pending		of Injury th, Day Year)	28b. Tim Inju		28c	. Injury Work	at ? es 2.⊟		28d. Describ	e how inp	ury occurr	ed		
Division of	Atten deat ctor: y the	Certification:	2 Accident	investigation 6 Could not be determined	9 20a Diago	of Injury - At	home, farm	, stree			03 2	-	28f. Location	(Street a	ınd Numb	er or Ru	ral Route f	Vumber,
á	i gate o	Serti	4 Homicide		buildi	ng, etc. <i>(Spe</i>	cify)		•				City or T	own, Sta	te)			
	6 4 P 9	edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	niner: On the ba	best of my kasis of examinar stated.	nowledge, d nation and/d	death o	occurred at statement of stigation, in	the time my opi	e, date an inion, dea	nd place, a th occurr	and due to the	e cause( e, date ar	s) and ma nd place, a	inner as and due	stated. to the caus	se(s)
	To the within 2 To the Complet	Me	29b. Signature and t	itle of certifier							number	_		29d. D	ate signed	d (Month	Day, Yea	r)
					1					D	35	0/2		00	tele	- 2	7,2	500
1	3		30. Name and addre		completed caus	e of death (It	em 23a) (Ty	/pe, Pr	rint)	K	lve	700		3el	Air	11	hd.	21014
	Sta Registr		31. Date filed (Month	10V 1	2007 32. 8	gistrar's Sig	nature	do	edi									21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 17 36808 Certificate of Death Rea. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 7:15 A M Frances Teresa Van Ryswick 2007 November /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Solomons Nursing Center Calvert Solomons 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2X F 85 **Director** 578-20-6475 December 12, 1921 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Maryland St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 42155 Medley's Neck Road 20650 ' USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: þ 3 ₩ Widowed 4 Divorced 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If Item 27 Is marked other tha any injury or other traumatic event, the once. 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Beall Caroline Loveless ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Wathen / Daughter 42155 Medley's Neck Road Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State November 9 Our Lady's Cemetery Leonardtown, Maryland 4 □ Donation 5 □ Other (Specify) 2007 21. Sign Jury of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 echaul 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1) ISEASE ARTER CORONAR **Physician** war /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ FAILURE CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform VASCULAR OLD CEREBRO 2 100 1 ☐ Yes 2□No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner?

1 Yes 2 140 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. M. nn Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital within 24 hours a To the Funeral C

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month 12) Yes 7

ANWAR MUNSHIM. D

Alla

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIE

303

30

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

110 DIOSPITALRD, PRINCE PREDERICK MD20178

State of Maryland / Department of Health and Mental Hygiene 36809 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 7, 2007 **Physician** 1:50 p M Reamy /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Mechanicsville 39256 Birch Manor Drive tf Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 8, 1927 6. Sex **Funeral**  Birthplace (State or Foreign Country) Days Hours Min 1 M 2 AF 80 Director Washington, DC 579-34-1283 Usuat Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, The Medical Examinar recognitions of the process. 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits Maryland Prince George's Brentwood Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3717 Taylor Street 20722 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be O'Neill Thomas Joseph Emma Elizabeth Owens 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas E. Reamy/ Son 39256 Birch Manor Dr., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Linciln Ceme. 11/12/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of Funeral Service Licensee M00817 Uw 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediete Cause (Final disease or condition resulting in death) Medantatio Physician Con (Er Ovarian /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. The law requires that the death certificate be executed burial-transit ed by the attending physicien and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 ☐ Probably ♦☐Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2□ No 1 Yes 2 (SA)0 1 Tyes or Attending Physician: the funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence Other (Specify Residence examiner' Hospital: ٩ 1 ☐ Yes 2 🕏 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Coutd not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a Hospite 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check unity 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar NOV 0 8 2007

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760.

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 7 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 8, 2007 <u>5:25</u> a<sup>™</sup> George Robert Ryan November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert 1175 Scenic Way Leonard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 151-16-6559 84 03/12/1923 New Jersey Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State rral", or items 23a or 28a-f show Examiner must be notified at 1 ∏Yes 2 X No Directo St. Leonard Maryland | Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1175 Scenic Way 20685 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 Nes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: ۵ 3 XWidowed 4 ☐ Divorced White "natural" Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Ordnance Specialist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Helen Higbee George Arthur Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5021 Martin's Point Road, Kitty Hawk, NC 27949 George R. Ryan, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic City Cem. 11/10/2007 Pleasantville, NJ 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Edward N. Brinsfield.Jr. Laura 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Taskic /Medical Due to (or as a consequence of): Examiner anci Sequentially list conditions, if my leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of) Attending Physician: The law requires that the death certificate be executed a ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No l or Attend after death. Director: / 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral I 1 Destriying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760.

State Registrar Rafik Nasr, M.D., 225 Town Square Drive, Lusby, Maryland 20657 31. Date filed (Month, Day, Year)
NOV 0 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b Signature and title of certified

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

8/07

07-08722 David John Schutz

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36811

David John School	1-	For State Certificate of Death	Re	eg. No.	2001 3001
Physician	_	. Decedent's Name (First, Middle, Last)	Date of Dea Month	Day Ye	3. Time of Death 2231 hrs
Medical Examine	er	DAVID JOHN DOROZZ	lovembe	9, 2007 4c. County	
<	4	la. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Easton		Talbot	of Death
		Easton Wellional Hospital	Date of Bi		Y) 9. Birthplace (State or
Funeral	- 5	Social Security Number 6. Sex Min. Months Days Hours Min.			Foreign
Director		129-44-5032   1XM 2 F   56 Yrs.   MAIN S S S S S S S S S S S S S S S S S S S	APRIL	30 1951	Country NEW YORK
		Usual Residence of Decedent 10c. City, Town or Location			10d. Inside City Limits
w an	- [	TACTION PACTON			1 X Yes 2 No
land f sho	٥١	MD TALBOT EASTON  10f. Zip Code		I0g. Citizen of V	Vhat Country?
Mary Mary	Director	tue. Street and Number	į		USA
11096 death with the Maryland or items 23a or 28a-f show		10 VILLAGE ST., APT 36 21601  12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specific Status)	ifv Yes or N	o- 14. Ra	ce - American Indian, Black,
h wit	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Wh	ite, etc.
r deal	ᇍ	Yes 2 X No specify		Specify	WHITE
s afte	ᇒ	or Dates:  15 Decedent's Usual Occupation (Give kind of works)	k done	16b. Kind of	Business/Industry
hour "nate	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			
136 hin 7, e. than	톍	12 CARPENTER			TRUCTION
d wit	ҕ	17. Father's Name (First, Middle, Last)  18.Mother's Name (Fi			ne)
215 De file ntal H ked o	8	WILLIAM B. SCHUTZ MARY CLA			our State Zin Code)
21 ould ould by Mer	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Run			
ND 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.		JACOB R. SCHUTZ/SON  2013 CASTLE PINES DR., 2020 Method of Disposition  2030 Method of Disposition  2040 Place of Disposition (Name of cemetery,	<b>KALI</b> Date	20c. Locatio	on - City or Town, State
re, s l an f Hea f fiter er tra		Comparison 3 Removal from State crematory or other place)			
altimore, mit. Pages I ar partment of He portant: If ite		CHESAPEAKE CREMATION CTR 1	1/13/2	2007 ST	EVENSVILLE, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	-	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  FELLOWS, HELFENBEIN	& NE	MAM FUI	NERAL HOME PA
m ed e iii		John M. Ostroski PPR DVR 200 S. HARRISON ST  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re	FASTO	V. MU Z.	1001
Physician / ical		failure. List only one cause on each line.			Between Onset and Death
aminer	1	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		h			
	ē	if any, leading to immediate  Due to (or as a consequence of):			
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated  counts resulting in death ) Last  Due to (or as a consequence of):			
d d ansit	Exa	events resulting in death) Last  Due to (or as a consequence or).  d.			
760, reate be executed g physician and the burial - transit	Medical	X AMENDED #21, perFH, C873, 11/17/07, WS/ #23a, 27, per	~ME ~87	7/ <sub>1</sub> 12/24	/O7 TT
60, ate be e	ledi	IF FEMALE: 23c. If yes, outcome of pregnancy	IIII. gov	23d. Dat	e or delivery
876 tificat ng ph as the	N/S	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnant	ісу	Mont	h Day Year
Box 687 e death certifice the attending led for use as the	/sician/l	Other (Specify)		787	
Bo e deat the at	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Di	d tobacco use c	ontribute to the cause of death?
Records, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physici page 2 should be denached for use as the buri	by P	Part II. Other significant conditions contributing to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to death but not resulting in the disconting accounting to the death but not resulting accounting to the death but not resulting in the disconting accounting to the death but not resulting accounting the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting to the death but not resulting accounting the death but not resulting accounting to the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting the death but not resulting accounting accounting the death but not resulting accounting accounting accounting accounting accounting a	1 🔲	Yes 2 V No	3 Probably 4 Unknown
S, E	pa		24a. W	as an 2	4b. Were autopsy findings available
ord: w requisibeen shoul	plet			topsy rformed?	prior to completion of cause of death?
ecc he lay ate ha	Completed			s 2 No	1 Yes 2 No
al R	a)	25. Was case referred to medical			C Other
Vita ysicir ihis ce direc	0. B.	1 V Yes 2 No	g Home 5	Residence be how injury or	
Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certific rs after death.  "In Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the	l ii	27. Manner of Death (Month Day Year)	280. Descri	be now injury or	Scarred
on tendii or: /	읉	Pending	ont I	- /Ctroot and N	iumber or Rural Route Number, City
Visi	<u>;</u>	3 Suicide 6 Could not be	or Tow	n, State)	difficer of Rular Route Rumber, eny
Dipital ours at tilled	Certification:	4 Homicide determined (Specify)		(-)	annos as stated
Division of Vital F To the Hospital or Attending Physician: ' within 24 hours after death. To the Finneral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at	aue to the a t the time, d	ause(s) and ma ate and place, a	and due to the cause(s)
Fo the vithin Fo the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, if my spinion, and manner stated.  29c. License number			signed (Month, Day, Year)
	ž	29b. Signature and title of certifier  O.C.M.E.			ber 10, 2007
	1	Mulline me was			
-		30. Name and address of person who completed cause of death (Item 23a)  Magnarita Korell MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
		Walgaria Notoli M.S.			
S Regis	itate stra	MOV 1 6 2007 Massac Com Application			W. W. W.
Kegis	-116	1997			ICME

		_ FOI	epartment of Health and Certificate of Death	Mental Hygien	2007 26912
A Physic		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Da	3. Time of Death
/Med Exam			4b. City, Town, or Location of Deat MillERSVille		County of Death
Funera Directo		X19.3011000 GO	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	Month, Day, Year	9. Birthplace (State or Foreign Country)  MARYLAND
with the Maryland a or 28a-1 show	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town  ANNE ARUNDEI  M	or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the a or 28a Lbv notili	Direc	10e. Street and Number  501 MARTIN TRIVE	10f. Zip Code	10g. Ci	tizen of What Country?
F-UU36 2 hours after death with the Maryla stural; or items 23a or 28a-1 shov	y Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Marned  1 □ Never Married 2 ☑ Marned  1 □ Yes 2 ☑ No If Yes, Give	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1  Yes 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
0 6 6	Completed by	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a.	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	rking 16b. H	(ind of Business/Industry
d Z I Z I Z I I I I I I I I I I I I I I			-OWNER, COACH	me (First, Middle, Maider	MNASCOM Sumame)
ylan ould be Mental Marked o	To Be	william C. PLUCK JR.	MAE	I. TAYL	OR.
Mar and 2 sh alth and 27 is m		H. JAMES SIMMS, HUSBAND 50		11	or Town, State, Zip Code)
More Pages 1 and of He not: If item			Disposition (Name of r. crematory or other place)	Date 20c. L	ocation - City or Town, State
Daltim permit. Pag Department Importent: any injury c		21. Signature of Fuleral Service Licensee	22. Name and Address of Facility Daugherty Family Funeral		
	ı	231. Part1. Enter the disease of employing that caused the math. Do no shock, or heart failure. List only on some or much line.	2601 Mountain Road	i - Pasadena MD. 2	Approximate Interval Belween Onset and Death
Physician /Medica Examine		disease or condition resulting in death)  Due to (or as a consequence of the control of the cont	n:	00.1.4	
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	C RICKLY ONS	ease	
cate be executed physicien and the burial-transit	Examin		tension	- 1	
os fou ificate be e g physicier as the burit	edical	Co. Chronic	Obstructive of	uluma	dire
death cert e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Suo 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
Ords, F.C. requires that the seen signed by the hould be detached.	by Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	1-	use contribute to the cause of death?
ecords law requires as been sign	Completed	anemia		24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
The The ate h				autopsy performed? 1 ☐ Yes N	24b. Were aulopsy findings available prior to completion of cause of death?  1 Yes 2 No
OI VITAL Physician:   This certifical ral director, p	To Be	examiner?	Cthon	ath (Check only bne)  Home 5 Residence	6  ☐Other (Specify)
ION OI nding Phy th. : After this s funeral d			me of jury 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how inju	iry occurred
LIVISION OI VIICA To the Hospitel or Attending Physician: within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)
e Hospit 24 hour e Funer etely fill	edical		death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the cause(surred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
To th within To th	Me	29b. Signature and fifts of certifier	29c. License number		ate signed (Month, Day, Year)
8		30. Name and address of person who completed cause of death (Item 23a) (	D43303 (Type, Print) 8028 Retchie	//-	12-0/
	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	8028 Ritchie	Try Pasa.	dena M) 21122
Regis		NOV 1 6 2007 Meline D. 19			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month de 1 20 **Physician** Carlton James 2007 Sprigale /Medical 4a, Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner -olumbia Howard Howard County General HUSPHAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 195-30-3090 Director 69 April 5, 1938 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 11044 Scotts Landing Road Funeral 20723 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify SpecWhite Completed by 3 Widowed 4 Divorced "natural", permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisory Fingerprint Specialist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Spriggle Blanche E. Bailey ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maxine Jean Spriggle/ Wife 11044 Scotts Landing Road, Laurel, MD 20723 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Mount Rock Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Tewistown, Pennsylvania 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 cernes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-transi and been signed by the attending physician should be detached for use as the buria Bladder Cancer Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 □ Yes 3 Probably 4 ☐Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has page 2 s autopsy perform certificate 1∐ Yes Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient ဥ After this 28a. Date of Injury funeral 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide hours after To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 24 one)

Box 68760,

P.0.

Records,

Division or Vital

State Registrar

31. Date filed (Month, Day, Year) NOV 01 2007

29b. Signature and title of certifier

32 Registrar's Signature

4801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ILLO

Behen

29c. License number

D 0044563

29d. Date signed (Month, Day, Year)

Hall Rd., Ellicott City, MD 21042

			1 - For State Registrar	State of	Marylai		artmen rtificat			nd Me		giene Reg. No		36	815
	Physici /Medi	cal	1. Decedent's Name (First, Middle	L. So	ih w	engel	4b City	Town or	Location of		Date of De Month	3 P	Year ZUS	7 116	of Death
	Examir	ier	4a. Facility Name (If not institution, Anne Arundel Med				Anna	epol:	is				Anne A	rundel	
	Funeral Director		517-24-7644	6. Sex 7 1 ☐ M 2√2 F		80 Yrs.	If Under Months	Days	If Under 2 Hours	Min. N	Date of Birl (Month Pa OV • 27,	<sup>th</sup> 1920	5 Wis	rthplace (Sta country) CONSIT	te or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	George's	10c. Ci Bow	ity, Town or Lo									e City Limits es 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 4005 Woodrow Lar	ie			10f. Zip	Code 20	715			10g. Cit	izen of What C	tates	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 ie marked other then "natural", or iteme 23a or 28a-1 ehow important: If item 27 ie marked other then "natural", or iteme 23a or 28a-1 ehow prip injury or other traumatic event, the Medical Examinar must be notified at ance.	by Funer	11. Marital Status 1 □ Never Married 2 🖔 Marri 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	es? ⊠No		Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- can, etc.)	-	14. Race - Arr Black, Wh Specify:		
21215-0036	in 72 ho n "natur	pieted	15. Decedent (Specify only highes	t grade completed)		16a. Deced	dent's Usua kind of wor	l Occupa k done d	ition furing most	of working		16b. K	ind of Busines	s/Industry	
	ed withing ygiene.	Comp	Elementary/Se <i>co</i> ndary (0.12)	College (1-4	or 5+) ~4	Child						Pul	olic Li	brary	
Maryland	should be filed with ind Mental Hygiene. marked other ther umatic event, Ing.	To Be Completed by	17. Father's Name (First, Middle, L John Blessing	.ast)							First, Middle, enfuss		Sumame)		
	1 and 2 sho Health and em 27 le my ither traum		19a. Informant's Name/Relationsh Kenneth E. Schwe		pand	19b. Mailir 4005	ng Address Wood]	(Street a	<sup>nd Number</sup> Lane T	or Rural R Bowie	oute Number, Mary	r, City o land	r Town, State, 20715	Zip Code)	
Baltimore,	permit. Pages 1 a Department of Hei Important: If item eny Injury or othe		20a. Method of Disposition  1 A Burial 2 Cremation  4 Donation 5 Other (Sp.		(	Place of Dispo cemetery, crem St Luthe	natory or of	her place	of Bowi	Date Le Ceme		c-2000	ocation - City o		
Balt	Departi Departi Importi eny inj		21. Signature of Funeral Service L	Boger	moto	/ B	5N3T18T 400 Pa	owde:	Böfgwa r Mill	erdt i l Roa	Funera d Belt	l Ho	ome, PA lle, Ma	ryland	20705
	Physician physician and physician and physician and physician and physician and physician sit and physician and ph	Icai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flag teaching to fining the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (ur	as a consect	quence of):	er the mode	a or aying	, such as c	ardiac or n	aspiratory ar	rest,		Approxii Interval I Onset ar	Between
P.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 1€ months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ⊡Feta tattime of d	ıl death 3 □	Ectopic pre						23d. Date of de Month	livery Day	Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to		No 3 P	o the cause of	
		Completed									24a. Was a autop perfor	sy	24b. Were a prior to death?	utopsy finding completion o	s available cause ol
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 X np	atient 2 🗆	ER/Outpatien	t 3□ DO/	Othe			heck only or	70	3 □Other (Spe	- 41	
Division of	ending sath. or: After he fune	Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time of Injury		Sc. Injury Work		280	. Describe h			iciry)	
É	5 H G	Certifi	4 Homicide determin	ned 286. Place of building,	etc. (Specif						City or Tow	n, State,			umber,
	he Hoepital n 24 hours a he Funeral I	Medicai	29a. Certifier (Check only one)  Certifying  2 Medical E	Physician: To the be xaminer: On the basi and manner	s of examina stated.	ition and/or inv	estigation,	in my opi	inion, death	occurred	at the time, o	date and	place, and du	to the cause	
	To the vithin 2 To the complet	Σ	29b. Signature and title of certifier	Sm			29c.	License	number 2 7 2		4	9d. Dat	e signed (Mon	th, Day, Year	)
(	P	8	30. Name an 1 ddress of person w	to completed cause of	of death (Item	n 23a) (Type, F	Print)			CL 2	.00	Λ.	(0.1)	MO 7	14 61
3)	Sta Registr	te ar	31. Date filed (Month, Day, Year)	2007	istrar's Signa	n 23a) (Type, F		- 11	0 0	>rC		1200	Man 3	712 6	. ~ 0 ;

		•	pe or Print in bi			•	•	
		1 - For State Registrar	State of Maryland	•	nt of Health and I te of Death		2007	36816
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physi /Med		Ellwood A	lelson S	harpe	SR:	Novembe		
Exam	iner	4a. Facility Name (If not institution, give str	2 . 1 1		, Town, or Location of Deat	h	4c. County of Dea	,
Funera		Social Security Number 6. Sex	tospital 7. Age (In yrs. Ia:	st birthday) If Unde	Easton er 1 Year   If Under 24 Hrs	8. Date of Birth	Ta/be 9. Bir	thplace (State or Foreign
Directo		×13-74-0599	4 2□F 6C	Yrs. Months	Days Hours Min.	June 9, 1	947 M	aryland
land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Mary Hefsh	ţō	MD Carolin	ne P	restor	1			1 □ Yes 2 12 No
death with the Maryland	Funeral Director	10e. Street and Number			ip Code	10g	. Citizen of What Co	ountry?
sath w	gra	22088-Marsh	. Was Decedent Ever in U.S.	pad	21655	anaifu Van an Na	ILS A	adaga Indiaa
or Item		11. Marital Status 12 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	to Rican, etc.)	Black, Whi	
d 21215-0036 filed within 72 hours after Hygiene "matural", or Ite ther than "natural", or Ite	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2. No Specify:		Specify: Blo	acK
15-I	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	rking 16	b. Kind of Business	/Industry
212 d with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	^	isor	#	teal th	Care
Ind 21215-0036  be filed within 72 hours after death with the Marylan lall Hygiene. d other than "natural", or liems 23a or 28a-f show event, the Medical Examinat must be notified at	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	me (First, Middle, Ma	iden Surname)	
Men Men	2	Otis Shar  19a. Informant's Name/Relationship (Type	Pe	10b Mailing Address	SS (Street and Number or Ru		irray	Tio Codel
- 6 - 0 -		Antoine Par	tan	22188 A	Jarsh Cres		eschall	VD 21655
Ord of H		20a. Method of Disposition  1	20b. Pla	ace of Disposition (Nametery, crematory or	ame of other place)	Date 20	c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of Hea Important: If Item any Injury or oths		4 □Donation 5 □Other (Specify)	Mt.	Pleasant	Cemetery 111		reston,	naryland
Baltimo		21. Signature of Funeral Service Licensee	26,000	22. Name a	and Address of Facility Funeval Ho Vashington	Me, P. A.	. 11. 1	10 21612
		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the eath.	Do not enter the mo	VOShing TON de of dying, such as cardia	ST. COME	oridge N	Approximate Interval Between
Physiciar		Immediate Cause (Final	(-as	_	avcinon			Onset and Death
/Medica Examine		resulting in death)	Due to (or as a conseque		ZVC NOW			year
L	ē	Sequentially list conditions, if any, leading to aumiculate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):				
cuted nd ransit	Examiner	that initiated events						
f60, te be executed ysicien and he burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):				
BOX 68 // Jeath certificate I attending physical of the tention of the tention of the tention of the tention of the tention of the tention of the tention of the tention of the tention of the tention of the tention of ten	edical	d.						
. BOX 68 death certifical e attending phy d for use as th	M/u	230. Was decedent pregnant	. If yes, outcome of pregnand		programa.		23d. Date of de	livery
	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of dea 9☐ Unknown				Month	Day Year
Jeta bet i	/Ph	Part II. Other significant conditions contri	buting to death but not result	ting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to	o the cause of death?
Mecords, the law requires t e has been signe age 2 should be o	ed by	Ronal Fo	rilure			Yes	2 □ No 3 □ P	robably 4 □Unknown
eco law re as bee	Completed	Sansis				24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	Con	99/				performer 1 ☐ Yes 2	d? death? No 1 ☐ Yes	2 □ No
Of VITAL Physiclan: Tribis certificet	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hos	ipital: 1 <b>X</b> Inpatient 2□EI	B/Outpotient OF F	Other	ath (Check only one)	- a = 0+ /0-	
g Physical direction	H-	27. Manner of Death		R/Outpatient 3 D 28b. Time of Injury	28c. Injury at Work?	lome 5 Residence 28d. Describe how		(city)
SIOP tendir leath. lor: Af	catic	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 ☐ Yes 2 ☐ No			
DIVISION  I or Attending after death.  Director: After tin by the fune	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, facto	ry, office	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
DIVISION O To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine)	ian: To the best of my knowl	o the best of my knowledge, death occurred at the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time			the cause(s) and manner as stated.	
the H hin 24 the F mplete	Medical	one)	and manner stated.					
Twit To		29b. Signature and title of certifier	81. 01	(	3c. License number	290.	Date signed (Mon	
		1 X P M	onni,		U412	24	11/02/	2007
		30. Name and address of person who com-	pleted cause of death (Item 2	23a) (Type, Print)				
	ate	Mary S. DeShields, 31. Date filed (Month, Day, Year)		rdy Stree	t, Ste. 101,	Easton, M	21601	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 2007 Helen Lee Shenk November /Medical 4c. County of Death 4a. Facility Name (If not institution, give\_street and number) 4b. City, Town, or Location of Death **Examiner** Genera Cambrid HOSAItal If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days 1 □ M 2X F Nov. 14, Virginia 95 1911 579-16-3786 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10h County iral", or items 23a or 28a-f show Examiner must be notified at Cambridge 1X Yes 2 No MD Dorchester Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 USA 908 Oakley Terrace Funeral 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No white Specify: þ Baltimore, Maryland 21215-003 3 □Widowed 4 □ Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event, the Medical once. 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator grocery store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ruffner James A. Bell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5951 Ross Neck Road, Cambridge, MD Janice Sellers niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/6/07 4 □ Donation 5 □ Other (Specify) Unity Washington Cem. Hurlock, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iterval Between
Unset and Death

34 40005 Intestinal Obstruction Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ို 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: Injury 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -043238 30. Name and address of person on completed cause of death (Item 23a) (Type, Print) Cambridge mo 21613 Tramble ot. 100

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 05

2007

32. Regimar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Ralph William Weagley November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death Examiner N.M.S Healthcare Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 21, 1922 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ▼ M 2 □ F 85 Director 216-14-6671 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10b. County 28a-f show notified at Director Sabillasville Md. Frederick 10e. Street and Number 10f. Zip Code a or 23a must 15516 Ouirauk School Rd. 21780 Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 1 Yes 2 No If Yes, Give 42-45 Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the 10 Clerk

10,2007 Year

4c. County of Death

10g. Citizen of What Country?

U.S.A

16b. Kind of Business/Industry

Supply Co.

20c. Location - City or Town, State

Garfield.Md.

12525 Bradbury Ave.

Smithsburg, Md. 21783

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24a. Was an

26. Place of Death (Check only one)

autopsy performed 1∐ Yes

4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

2 No

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

Lulu Grace Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13223 Herman Myers Rd. Hagerstown, Md. 21742

Date

Nov. 15,

2007

14. Race - American Indian, Black, White, etc.

White

Approximate Interval Between Onset and Death

Year

Washington

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Maruland

Physician /Medical

27 Is marked other ir traumatic event, tl

1 and 2 should be and Mental

Health a

Pages 1

Department of Health Important: If item 27 any Injury or other tr

Be

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Je Pc

Immediate Cause (Final

Sequentially list conditions

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 ☐ Yes 2 ☐ ANO

. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

IF FEMALE:

disease or condition resulting in death)

Omar Weagley

Kelly R. Weagley (Son)

N Burial 2 ☐ Cremation 3 ☐ Removal from State

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Examiner

burial-transit physician the as use for g director, page 2 should funeral

Physician/Medical Examiner

þ

Completed

Be

Certification: To

Physician: The law requires that the death certificate be executed the þ certificate has this After t Hospital or Attending death. Director: filled in by hours after within 24 hours a

Division or Vital Records, P.O. Box 68760.

31. Date filed (Month, Day, Year) State 16 Registrar DHMH 17 Rev 1/2001

5 ☐ Pending investigation

6 ☐ Could not be determined



Khalid Waseem M.D. 1126 Opal Ct. Hagerstown, Md. 21742

**ORIGINAL** 

20b. Place of Disposition (Name of cemetery crematory or other place)
Garrield United

M01414

estille

Due to (or as a consequence of):

Directo (or as eleossequence of)

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 🗀 Inpatient

(Month, Day Year)

28a. Date of Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4☐Pregnant at time of death 9☐Unknown

ona

3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Methodist Church Cem.

3 Ectopic pregnancy

Other:

1 ☐ Yes

2 □ No

28c. Injury at Work?

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

075353

5 Other (specify)

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

22. Name and Address of Facility

J.L. Davis Funeral Home

State of Maryland / Department of Health and Mental Hygiene 36819 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** MILDRED MATTIE VAN DER WENDE NOV. 2007 /Medical 2:27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🕱 F Director 141-14-7061 NOV. 17, 1921 NEW JERSEY Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23e or 28a-1 show other traumatic event, the Modical Examiner must be notified at 1X Yes 2 No Director MD QUEEN ANNE CENTREVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 101 WEEDON STREET 21617 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ MEN No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WEAVER/FABRIC MAKER 10 TEXTILE permil. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD HANLON O'NEAL MARY BESSINGER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD VAN DER WENDE/SON 101 WEEDON STREET, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 11-2-2007 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funey Syrvice Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failur one cause on such line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** phasia Due /Medical (or a a consequence of): Examiner ukmoni sm rears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissass or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed the burial-transit Due to (or as a consequence of): physician P.O. Box 68760 Physician/Medicai attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Yes ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2200 2 \( \text{No} \) 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA To the Hospitel or Attending Pt within 24 hours after death.
To the Funerel Director: After th completely filled in by the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tutilmans Lane, Easton, MD 31. Date filed (Month, Day, Year) Registrar

			_ For		partment of Health and			
			1 - State Registrar	Ce	ertificate of Death	Reg	N2007 36820	
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	
	/Medic	cal	Henry Thomas V  4a. Facility Name (If not institution, give stre	Wilson	4b. City, Town, or Location of Deatl	November	6, 2007 5:15 p <sup>M</sup> 4c. County of Death	
,	Examin	ier	St. Mary's Nursing		Leonardtown	'	St. Mary's	
-	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, Ye	Birthplace (State or Foreign	
	Director		247-22-8615	1 2□ F Yrs.	Months Days Hours Mill.	09/16/19		
	w		Usual Residence of Decedent  10a, State  10b. County	10c. City, Town or I	Location		10d. Inside City Limits	
	Maryli f sho led at	ō	Maryland St. Mary's	Great Mi	<b>;</b> 110		1 □Yes 2 No	
	r 28a- notif	Directo	10e. Street and Number	Gleat M	10f. Zip Code	10g	. Citizen of What Country?	
	th with		45803 Strickland Roa	ad	20634	Un	ited States	
	ems er mu	Funeral	11. Wantar Status	. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.	
S	s afte ,'or if	by Fi	1 ☐ Never Married 2 ※ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White	
3	e filed within 72 hours after death with the Manyland al Hygiene. al Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notifiled at	ed t	15. Decedent's Educat	tion 16a. Dec	cedent's Usual Occupation	16	b. Kind of Business/Industry	
ດ ເກີນ	hin 72 e. an "na Medic	plet	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) (Giv College (1-4or 5+)	ve kind of work done during most of wor . DO NOT use retired)	rking		
7	ed wit /giene er the t, the	Be Completed	12		ght Engineer		S. Government	
and			17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma.	,	
⋝	2 should be and Menta is marked aumatic ev	မ	Roscoe Horton  19a, Informant's Name/Relationship (Type.	Wilson	Lila illing Address (Street and Number or Ru	Mae Cor		
<u> </u>	ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		Margaret H. Wilson/	· ·	3 Strickland Rd.,			
ē,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place)		c. Location - City or Town, State	
altimo	permit, Pages Department of Important: If i any Injury or once.		1 ☐ Burial 2 【XCremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other ( <i>Specify</i> )	noval itom State	ld-Echols Cre 11/1	0/2007 Ch	arlotte Hall, MD	
ä	permit. Departr Importa any Inju		21. Signature of Funeral Source Ticensee	3	22. Name and Address of Facility Br	insfield	Funeral Home, P.A.	
_	20 <b>5 8 9</b>		Edward N. Brinsf:					
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	lions that caused the death. No not e cause on each line.	enter the mode of dying, such as cardia	or respiratory arrest	Approximate Interval Between Onșet and Death	
,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Esqualoyy faulty					
	Examiner			Due to (or as a tons, juence of):	al Carba	1/1/2	341	
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a - onsequence of):	The Charles	1.	- 111	
	ecuted Ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Jarbens	Lons Dema	nlea	920	
6/60,	cate be executed thy sician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):			10	
200	certificate be executed adding physician and use as the burial-transit	dical	d					
×	leath certifica attending ph	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome pf pregnancy			23d. Date of delivery	
-	death e atten	icia	in the past 12 months? 1 □ Yes 2 □ No		3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>		Month Day Year	
Э	at the	Physician/Med	9 ☐ Unknown					
Š,	w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions contri	outing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?  2   No 3 □ Probably 4 □ Unknown	
coras	requi	Completed						
Œ	sician: The law certificate has bi irector, page 2 sh	du				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?	
	n: Th ficate or, pag		25. Was case referred to medical		00.51(5	1□ Yes 2¶	No 1 ☐ Yes 2 ☐ No	
	Physician: r this certificaral director, I	o Be	examiner?	spital: 1 ☐ Inpatient 2 ☐ ER/Outpati	Other:	ath <i>(Check only one)</i>	ce 6 □Other (Specify)	
0	ding Physician: n. After this certific funeral director,	<del> </del>	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how		
Vision	endin ath. or: Aff	atio	1 Natural 5 Pending 2 Accident investigation	(World, Bay Your)	M 1 ☐ Yes 2 ☐ No			
<u> </u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)	
_	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
	e Hos 24 hc e Fun etely	ledical			investigation, in my opinion, death occ			
	To the within To the Complex c	Me	29b. Signature and title of certifier	0/1	29c. License number	29d	. Date signed (Month, Day, Year)	
			am	H Laws X	U) D06419		11-7-07	
			30. Name and address of person who comp	/ 4	•			
		12.5	James P. Jarboe, 240	035/Three Notch Ro 32. Registrar's Signature	d., Hollywood, Mar	yland 206	36	
	Sta Registr		NOV 0 9 2007	A drawler				

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

6 2007

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-08594 State of Maryland / Department of Health and Mental Hygiene Candace Young Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day November 5, 2007 Physician/ 0352 hrs Medical Examiner CANDACE YOUNG c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number ForeignTRINIDAD Country TOBAGO **Funeral** Min Months Days Hours 03/18/1980 Director M 2 X F 27 Yrs NONE Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 X Yes 2 No s 23a or 28a-f show notified at once, CLINTON PRINCE GEORGES Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TRINIDAD & TOBAGO 20735 12302 BROLASS ROAD 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. marked other than "natural", or items c event, the Medical Examiner must be Armed Forces? 1 X Never Married 2 Married 2 X No Yes Yes 2∑ No specify: Specify: BLACK If Yes, Give Year Divorced Widowed hours after ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lant of Health and Mental Hygiene, ant: If Item 27 is marked other than "r Baltimore, MD 21215-0036 PRIVATE LABORER 4+ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CICELEY JONES Be NEVILLE YOUNG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ 160 THE ESPLANDADE #318 TORONTO ONTARIO, CANADA NEVILLE YOUNG / FATHER 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State ALEXANDRIA, VA METROPOLITAN CREMATORY 11/21/2007 permit. Page Department of Important: injury or oth Donation 5 Other Specify 22. Name and Address of Facility
MARSHALL'S FUNERAL
4308 SUITLAND ROAD natur o Funeral Service License HOME OF MARYLAND, INC. SUITLAND, MD 20746 Approximate Interval rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician lure. List only one cause on each line Death **1edical** Complications of renal disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and tran sician/Medical X UNPENDED physician the burial -1/9/08 TI 27 perME.g875 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE. Year Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 ✓ Yes 2 No 9 Unknown ned by the atte Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 þ σ. Completed 24b. Were autopsy findings available Division of Vital Records. 24a. Was an prior to completion of cause of autopsy death? performed? ✔ Yes 2 1 V Yes 2 Nο 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> Hospital: Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient this 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Certification: Yes 2 1 X Natural death. Pending Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. within 24 hours after To the Funeral Dire or Town, State) 3 Could not be Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier November 5, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 32. Registrar's Stgna ure 31. Date filed (Month, Day Year) State 3 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 2006 07-08848 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Vincent Adams 2007 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year November 14, 2007 1808 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 1811 Bank Street Baltimore 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 5. Social Security Number **Funeral** Foreign Months Days Hours Min. Director Country) 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No items 23a or 28a-f show hours after death with the Maryland Director 10f. Zip Cøde 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married 2 V NO Yes 1 Yes 2 No specify: Divorced If Yes, Give Year Specify: Widowed permit. Pages 1 and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 9Ablea 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State **Physician** /Medical caminer

Division of Vital Records, P.O. Box 68760,

To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b

Physicia
ģ
pleted
Com
Be
٩
:ation:
ca

Medical

State Registrar

29a. Certifier

29b. Signature and title of certifier

Tasha Greenberg MD. 31. Date filed (Month, Day, Year)

	p			ısit	
	r Attending Physician: The law requires that the death certificate be executed		irector: After this certificate has been signed by the attending physician and	by the funeral director, page 2 should be detached for use as the burial - transit	
131011 01 11101 10001 001 101	tificate b		ng physic	as the bu	
	death cer		e attendi	for use	
	that the		ned by th	detached	
5	requires		been sig	hould be	
	The law		icate has	page 2 s	l
	ysician:		his certif	director,	
5	ding Ph.	'n.	After tl	funeral	
2	· Atten	er deat	rector	by the	

	4 Donation 5 Other Specify:	Ja	YVIEW Crei	natory //	-17-07	Da 17more	(111)		
	21, Signature of Funeral Service Licensee		22. Name and	Address of Facility	radley-	Ashton	=uneral		
	the the later	Margarities of	Home	PA, 213	34 Ni 110W	SACINGA	ood 21222		
	23a. Part I. Enter the disease, or complica	tions that caused the death.	Do not enter the mode	of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and		
	failure. List only one cause on each	line.		\ intovication	and cocaina	uco com licat			
		arcotic (mon hine			and cocamie	use outpilled	<u>ed</u>		
	Due	e to (or as a consequence of	by priedinorm	1		1			
_	Sequentially list conditions,	o to for as a consequence of	١٠						
<u>=</u>	if any, leading to immediate Due to (or as a consequence of):								
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
	d								
g	X UNPENDED A	MENDED		/22					
edi	Activities		erME.g875, 1/	11/08 TT		23d. Date of delivery			
ξ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		3 Ectopic pred	nancy	Month Da	v Year		
ä	past 12 months?	4 Pregnant at time of dea			,		,		
ŝ	1 Yes 2 No 9 Unknown	g Unknown	o Ciller (opt						
Physician/Medical	Part It. Other significant conditions co	entributing to death but not re	esulting in the underlyin	g cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?		
ģ		v			1 Yes	2 No 3 Proba	bly 4 🗸 Unknown		
eq	-				24a. Was an	24h Were sute	psy findings available		
je					autopsy	prior to co	mpletion of cause of		
Completed by					perform	ed? death? No 1 ✔ Yes	2 No		
ပိ	25. Was case referred to medical			26.Place of Death (Che	ck only one)				
Be	examiner?   Hos	pital: 1 Inpatient 2	ER/Outpatient 3	·O4		esidence 6 🗸 Other:	Scene		
9	1 Yes 2 No	28a. Date of Injury	·	28c. Injury at Work?	28d. Describe ho				
ä	27. Manner of Death  1 Natural 5 Deading	(Month, Day,Year)	200. Time of Injury	_		w mjary occurred	- "		
The state of the s									
Certification:	Accident Survey and Number or Rural F Suicide Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural F or Town, State)					al Route Number, City			
ert	4 Homicide determined	(Specify) found at	home		1811 Bank	St. Baltimore	, MD		
C	One Continue						7.00		

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

November 15, 2007

**ORIGINAL** 

Assistant Medical Examiner

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month George Boone 0 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deaf **Examiner** Carroll Hospital Center Westminster Carrol1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 220-16-3766 80 Director Ju1y 19 1927 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Carroll Westminster 1 ☐ Yes 2**∑** ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Treemont Dr. Apt. 8 21157 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Tyes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🗓 Married Korea Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white φ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ transportation truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Boone Catherine Harden 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor Boone (spouse) 500 Treemont Dr. Apt. 8, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Pleasant Cemetery 11-20-07 Gamber, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC FIBRILLATION /Medical Due to (or as a consequence of): Examiner HRTERY CORONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician; The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 E No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15433°

DHMH 17 Rev 1/2001

Registrar

200 MEMORIAL AVENUE

WESTMINSTER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

ASHRA

NOV 1 9 2007

MAHBOOB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Mai Bunapai \*/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 215 MORC UI —
Inder 1 Year If Under 24 Hrs. 8. Date of Birth
Min. Min. Autorith, Day, Baltimore ente 7. Age (In yrs. last birthday, Yrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 219-90-214 Usual Residence of Decedent 1 ☐ M 2 ☐ F Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Mary and Number Funeral Director timore 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 17 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ican Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ¥ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: P Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Bull (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ew 1an 19a. Informant's Name/Relationship (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Type. Print) 32 N. Moun MD 20a. Metilod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 9/2007 Glen Burnie 4 □ Donation 5 ☐ Other (Specify) 21. Signatur of uneral Service Licensi Funeyal Hom, P.A. Ave. Balton, MD 21216 23a. Part1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cancer gmonths cervica /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ has been sig ge 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an autopsy page certificate or Vital 1∐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2**X** No Hospital: 1 🗌 Yes <sup>2</sup> 1 Inpatient 2 ER/Outpatient 3□ DOA 5 🗆 Residence 6 ☐Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division To the Hospital or Attending 1) Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No dea h. investigation neral Director / 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Division

ace

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IM

Saint

Pa

yrone Barnes, Jr	1- For State	tate of Maryland	d / Departm <i>Certifi</i> c	nent of cate of	Health and <i>Death</i>	Mental I	Hygiene	Reg. No	20	07 3682
Physician/ Medical Examiner		dle,Last)	Barn	nes, J	r.		2. Date of Month	of Death Day mber 14,	Year	3. Time of Death 2129 hrs
A CALLETTINE	4a. Facility Name (if not institut 9807 Langs Road #0		er)	4	b. City, Town, or L Middle River	ocation of Dea		- 4	lc. County of De Baltimore C	
Funeral Director	5. Social Security Number 216–98–5104		Age (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days			of Birth (MN		Birthplace (State or reign Md.
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	on					10d. Inside City Limits
<b>8</b> .,	Md. 1	NA	Es	ssex	10f. Zip Code			10g. C	itizen of What C	1 Yes 2 No
eath with the Maryland items 23a or 28a-f shoust be notified at once ust be notified at once uneral Director				142.14(04	2122 Decedent of Hisp		Specify Ves	or No	USA	merican Indian, Black,
김 호텔 교	3 Widowed 4	12. Was Deced  Armed Force  1 Yes  ivorced If Yes, Give Year		If Ye	es, specify Cuban,	Mexican, Pue			White, etc.	1
11215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. narked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once on Be Completed by Funeral Director	15. Decedent's Education (Sp	ecify only highest grade		a. Decedent during mo	's Usual Occupationst of working life.	on (Give kind		e 16b	. Kind of Busine	
21215-0036 Juld be filed within 72 he Mental Hygiene. marked other than "na re event, the Medical Ex To Be Complete	GED 17. Father's Name (First, Midd)				employed	8.Mother's Na			NA en Surname)	Creaham
21215-0036 ould be filed within 72 h d Mental Hygiene. s marked other than "" tic event, the Medical E To Be Complete	19a. Informant's Name/Relation	nship (Type, Print )		19b. Mailing	Address (Street	and Number		ite Number,		
MD and 2 sh and 2 sh and 27 is m 27 is rauma	Lynette Burge 20a. Method of Disposition		20b. Plac		Kirkwood		Date	20	c. Location - Cit	207 cy or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti	1 X Burial 2 Cremati 4 Donation 5 Other 21. Signature of Funeral Service	Specify:		ng Me	m. Pk. lame and Address 101 E. N		1-17-0 March			stown, Md.
한 월경토토 Physician	23a. Part I. Enter the disease, failure. List only one cau		sed the death. Do							. 21202  Approximate Interval Between Onset and
/M dical aminer	Immediate Cause (Final disea or condition resulting in death)	se a. Multiple Gun								Death
iner	Sequentially list conditions, if any, leading to immediate	b Due to (or as a co	onsequence of):							
uted ransit  Examiner			onsequence of):							
50, te be executed systician and burial - transit		AMENDED 23c If yes ou	tcome of pregnan	icv					23d. Date of de	livery
Box 68760, re death certificate be the attending physic red for use as the bur Physician/Mec	23b. Was decedent pregnant in past 12 months?	the 1 Live birt	th nt at time of death	2 Fe	etal death 3 ther (Specify)	Ectopic pre	egnancy	_	Month	Day Year
P.O. Bc s that the de- gned by the s s detached fi			death but not resu	lting in the u	underlying cause (	iven in Part I.				te to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. Box 68760. To the Hospital or death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Re Completed by Physician/Me							-	a. Was an autopsy performe	prio d? dea	ore autopsy findings available or to completion of cause of ath?  Yes 2 No
tal Rec		Utanaital				of Death (Ch			sidence 6	
n of Vi ding Physi a. After this funeral dir	1 Yes 2 No	28a. Date of FOUND:	f Injury 28	R/Outpatient  Bb. Time of  OUND:	Injury 28c. Inju	ry at Work? Yes 2 ✔ No	Subia		injury occurred	
Division or spital or Attending sours after death. neral Director: After filled in by the funer Certification:	2 Accident In 3 Suicide 6 C	vestigation ould not be Nov 14, 2	of Injury - At home		et, factory, office t	ouilding, etc.	or	Town, State		or Rural Route Number, City
To the Hospital within 24 hours a To the Funeral completely filled		Physician: To the best examiner:On the basis of	of my knowledge, examination and/	death occu	rred at the time, dation, in my opinion	ate and place, n, death occur	and due to	the cause(s ne, date and	) and manner as I place, and due	s stated. e to the cause(s)
To roo	29b. Signature and title of cer	and manner sta	neu.		29c. Licens				9d. Date signed November 1	(Month, Day, Year) 5, 2007
7	30. Name and address of personal Ana Rubio MD.	son who completed cause Assistant Medical E			Street, Baltim	ore, MD 2	1201			
Stat Registra			pistrar's Signature	Agram	e de			-		

07-08374		Please Type	or Print in B	lack Inde	lible Ink.	Ensure All Copie	es Are Legi	ible.	
Roosevelt Corneliu	1	- For State	of Maryland		ent of Hea ate of Dea	alth and Mental H ath		. No. 200	7 3682
Physician		egistrar I. Decedent's Name (First, Middle,La	st)				2. Date of Death		3. Time of Death
Medical Examine		ROOSEVELT	CURNE		BUR		Month October 27	, 2007	1634 hrs
( )	ľ	ta. Facility Name (if not institution, given 15607 Mews Court	e street and number	r)		y, Town, or Location of Deatl 1ham	i	Prince George	's
Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. last bi		nder 1 Year If Under 24Hr	_	(MM/DD/YYYY) 9. Birt	nplace (State or
Director	1	579-94-2276	<b>×</b> M 2 F	62	Yrs. Mo	nths Days Hours Mir	02/24	11945 Col	TAMAICA
апу		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	n or Location		•		10d. Inside City Limits
d See de		MD PRINCE	GEORGES	LAUF					1 Yes 2 No
farylan	Ulrector	10e. Street and Number	4-CN4L 3	T ACTION A		Zip Code	10	g. Citizen of What Cour	itry?
10 %0		15607 Mew	5 Court			20707		USA	
116 in with with with with with with with with	unerai	11. Marital Status  1 Never Married 2 Marrie	12. Was Deceder Armed Forces	3?	13. Was Dece If Yes, spe	edent of Hispanic Origin? ( S ecify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ier dea ", or ii er mus	ᄔ		1 Yes d If Yes, Give Year	2 🗶 No	1 Yes	2 No specify:		Specify: B	ack
ours af atural	δ D	15. Decedent's Education (Specify of	or Dates:	ompleted) 16a		ual Occupation (Give kind of working life, DO NOT use re		16b. Kind of Business/I	ndustry
36 in 72 h han "n lical E	ompleted	Elementary/Secondary (0-12)	College (1-4 o	r 5+)	1	Preneur		Private	
imore, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Titien 27 is marked other than "natural", or items 23a or 28a-f show or other trannaite event, the Medical Examiner must be notified at ouce.	탉	17. Father's Name (First, Middle, Las	t)		<u> LN1/e</u>		e (First, Middle, M	aiden Sumame)	
21215 und be file Mental H marked o	å	George F	). Burke			Love	New		7.0.1.
D 21 Should and Me and Me 7 is ma	<u> </u>	19a. Informant's Name/ a Tonship (	Type, Print )	10	9b. Mailing Addr	ress (Street and Number or	A 1	per, City or Town, State	, Zip Code) ついつせん
e, MD and 2 sho fealth and item 27 is	1	20a. Method of Disposition	rne			Name of cemetery,	Date	20c. Location - City or	Town, State
MOFE Pages 1 nent of 1 nnt: If i		1 Burial 2 Cremation 3 4 Donation 5 Other Specific		State Rue	atory or other pla	hok coemNh	V. 7. 200	Russdal	e MD
Baltimore, ME permit. Pages 1 and 2 s Department of Health at Important: If item 27	t	21. Signator / Fur era Se Le Lice		- INTAC		and Address of Facility	arks Hi	NOS FUNEN	al Service
	1	23a. Part I. Enter the disease, a con-	blications that cause	ed the death. Do	not enter the mo	de of dying, such as cardiac	or respiratory arre	st, shock, or heart	proximate Interval
Physician M. dical	70	failure. List only one cause on e	each line. a. As, hyxia						Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor	sequence of):					
	۱,	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	sequence of):					<del> </del>
	xamine	cause Enter Underlying Cause	o						
cecuted and and - transit	Exa	events resulting in death) Last	Due to (or as a cor	isequence of):					
icx 68760, eath certificate be execut a strending physician and for use as the burial - transfer.	Physician/Medical E	X UNPENDED		28a-f no:	-ME 0875	1/4/08 TT			
68760, certificate be ding physic se as the burning control of the	ğ	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outo	come of pregnance	су			23d. Date of deliver	y Day Year
K 68	cian	past 12 months?		at time of death	Fetal de  5 Other (		nancy	I WORK!	July 10an
Box e death c the atten ed for us	lys.	1 Yes 2 No 9 Unknow	5 GIRIOWII			Dent I	23a Did to	bacco use contribute to	the cause of death?
cords, P.O. Be law requires that the de that been signed by the should be detached for	و م	Part II. Other significant conditions	s contributing to de	ath but not resul	ting in the under	lying cause given in Part i.		2 No 3 Pro	
ds, last equires	g						24a. Was a		utopsy findings available
COF	Completed	\ <del></del>					autop perfor	med? death?	completion of cause of
il Re	24a. Was an autopsy find prior to completion death?  25. Was case referred to medical examiner?  1								
Vita hysicia this ce	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpa		/Outpatient 3		•	Residence 6 V Other	r: Scene
1 of Vit	n:	27. Manner of Death  1 Natural 5 Pending	28a. Date of I (Month, Da	njury 28 y,Year)	b. Time of Injury	28c. Injury at Work?		now injury occurred	
Aften Aften r ceath ector: br the	cati	2 Accident Investiga	ation Find 10/		Nd 4:34 pm	n A tory, office building, etc.	28f. Location (S		ural Route Number, City
Division of Morrisal or Attending Ph. 24 hours after death. Funeral Director: After tely filled in by the funeral	1								, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 holls after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in br the funeral director, page 2 should be detached for use as the burial - transit	29a. Certifier (Check only one) 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								ted.
To the within 7	Medical	one) 2 Medical Examin  29b. Signature and title of certifier	er:On the basis of e and manner state	xamination and/o	or investigation, ii	29c. License number	or are arre, date	29d. Date signed (Me	
(8		Lower Inc.	Dinul Imi	D.		O.C.M.E.		October 28, 200	
								1	

State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

NOV 1

Donna M. Vincenti, MD Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

			For Amend Item 2  State Registrar	State of Maryland	<b>Cer</b>	<b>5/07dhb</b> tificate of l	Death	vicinality	Reg. No. 🤈 🕦	0.7	36928
			1. Decedent's Name (First, Middle, Last)	4				2. Date of De		<del>U /  </del>	3. Time of Death
	Physicia		HAZEL B	ROWN				Month //	Day	Year	455 PM
<b>)</b>	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County	of Death	
			UNIVERSITY OF	MARY CAN		BAZ	7700020	5			
	Funeral		Social Security Number 6. Sex	0 1	- 1	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	h v. Year)	9. Birthpla Countr	ce (State or Foreign
	Director		216-30-0029	M 2[XF 71	Yrs.	Wioritis Days	TIOUTS WIII.	Jan 24	1936	Maryl	
	pu.		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	ration				100	d. Inside City Limits
	aryla shov	۲ ا				Janon					1 ∐Yes 2 🛣 No
	he M	Director	MD Howard  10e. Street and Number	Lau	ırel	106 7in Code			10g. Citizen of V	What Countr	
	a or					10f. Zip Code					y :
	eath is 23	eral	9330 Decatur Place	E I2. Was Decedent Ever in U.S	3 13 1	20723		necify Ves or No	U.S.A	e - Americar	n Indian.
_	ter d item iner	Funeral	11. Marital Status  1 □ Never Married 2 ★ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	J. 10. 1	Vas Decedent of H Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	Blac	k, White, et	
-0030 -0036	irs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify	. Whit	e
F	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at		15. Decedent's Educ	eation	16a. Deced	ent's Usual Occup	ation		16b. Kind of Bu	ısiness/Indu	stry
υ Ω	hin 7. an "n Medi	ble	(Specify only highest grade Elementary/Secondary (0-12)	Completea) College (1-4or 5+)	(Give life. L	kind of work done o OO NOT use retired	during most of wor d)	king			
7	filed within Hygiene. ther than "	Completed	12		Line	Technic	ian		Electro	nics	
2	- 0 2	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surnan	ne)	
<u> </u>	thould be id Menta marked matic ev	2	Paul Frazier				Hazel M	aybell I	Fincham		
<u>a</u>	2 shc and is m		19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip C	Code)
≥ ~``	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic			ouse		Decatur					
5	0 0		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Re	emoval from State	emetery, cren	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or Tow	n, State
	: Pa tmen tant: jury		4 □ Donation 5 □ Other (Specify)			lge Mem P		16, 07	Dorsey,	Mary.	land
ä	pcrmit. Pag Department Important: I arry injury o		21. Signature of Funeral Service Licens	///	<sup>22</sup> I	. Name and Addres	ss of Facility Funeral	Home, H	P.A.		
	E05 % 0	3-3	Solve (the )	M007		313 Talbo					
			23a. Part1. Enter the Javase, or compli- shock, or heart fail the. List only on	e cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	MULTIPL	E Sy	STEM	ORGAN	FALL	LINE		6 DAYS
	Examiner		4	Due to (or as a consequence of the consequence of t	ence of):	16-00		-/0	6 A-C- 11 m	PATHY	12 Hou
	95-38	<u>-</u>	Sequentially list conditions, if any, leading to immediate	ue to (or as consequ	ence of):	MEIN	UPSICHTE	76/ (	HOULE	711/17	1-1(00)
	uted insit	Examiner	Cause (Disease or injury	PAST C	DAL	ATIVE	CARDI	te F	ALLUR	ε	12 HOUR
,	execu n and ial-tra	Exal	that initiated events cresulting in death) Last	Due to (or as a consequ	ence of):	.,, ,,,,	1	MOLLEN	WAN EXAMINER		
2/00	icate be executed physician and the burial-transit	dical				,	$\Lambda / I \Lambda$	DROVED BY ME	DICAL		
00	ifficat g phy as the					1	TISCOTION	Al	- 4-		
ŏ	death certif e attending d for use a	2	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome pf pregnar 1□Live birth 2□Fetal	ncy	Ectopic pregnancy	17-7		i	te of deliver	
ם	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of de		Other (specify)	_/		Ma	onth E	Day Year
5	at the by th tache	Physician/M	9 ☐ Unknown								
'n	The law requires that the death certific tee has been signed by the attending page 2 should be detached for use as	by F	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	iderlying cause give	en in Part I.				cause of death?
coras,	equir sen si ould							1 🗆	Yes 2 No	3∐ Proba	bly 4 □Unknown
ပ်	law r as be 2 sh	ple						24a. Was auto	an 24b.	Were autop	sy findings available pletion of cause of
ב =	The	Completed						perfo 1∐ Yes	rmed?	death?	No
	siclan: The law certificate has b irector, page 2 s	Be (	25. Was case referred to medical examiner?			Lou	26. Place of Dea	th (Check only o	one)		
5	physi this o	၉	Tes ZATAO		ER/Outpatien		4 L Nursing H		dence 6 □Oth		
	ling f	ü	27. Manner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl		280. Describe	how injury occur	rea	
VISION	death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At hor	me farm str		Yes 2 □ No	28f Location /	Street and Numb	ner or Rural	Route Number
<u> </u>	after Direc	Certification:	4 ☐ Homicide determined	building, etc. (Specify	)	oct, lautory, office		City or To		ei oi i leiar	noate variber,
	spita nours neral		29a. Certifier 1 Certifying Phys	ician: To the best of my knov	vledge, death	occurred at the tir	me, date and place	, and due to the	cause(s) and ma	anner as sta	ited.
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director, the funeral director is the funeral director.	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examinati and manner stated.	ion and/or in	estigation, in my c	ppinion, death occu	irred at the time,	date and place,	and due to	the cause(s)
	Veith To t	Σ	29b. Signature and title of certifier	Cl. P11	7	29c. Licens			29d. Date signe	d (Month, D	lay, Year)
	4		· yeoffrey 16	. suinfeld	NU	MG	3927	•	11/13	190	07
	1		30. Name and address of person who co		23a) (Type,	Print)	22 Scil	THE	MEEN	57	pate.
11	)		SHEINFELD (	TEOPPREY	2	111	/		. 4 -	2	21201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** IRVIN JAMES BAUERLIEN NOV. 14, 2007 10:45 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 20 BUCHER JOHN RD. CARROLL UNION BRIDGE 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2∏ F Yrs. Director 219-20-3924 81 1/16/1926 MARYLAND Usual Residence of Decedent r 28a-f show notified at 10c. Cify, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be not the traumatic event, 838 OLD MANCHESTER RD. 21157 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: WHITE 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry TOOL Elementary/Secondary (0-12) College (1-4or 5+) FACTORY WORKER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f h and Mental H CASPER J. BAUERLIEN LILLIAN L. TURFLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 t of Health a if item 27 is JANET M. STEPHAN -DAUGHTER 20 BUCHER JOHN RD., UNION BRIDGE, MD 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages ' 1 Mg Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury or Department of Important: if any Injury or WESTMINSTER CEMETERY 11/17/07 WESTMINSTER, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Igna Plan Fyreral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Part1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a sequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit and Due to (or as a consequence of): Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 cate h Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DAUGHTERS 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this HOME 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: **Hospital or Attending** Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: on the basis of examination of and manner stated. seath occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completes em 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

NOV

Division or Vital Records, P.O. Box 68760,

To the Hospital within 24 hours a To the Funeral I

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

and manner stated

Rence 32. Régistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year ERIC 8:45 P CLARK 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 852 PEACH ORCHARD LANE TURNER STATION BALTIMORE Date of Birth (Month, Day, Year) 12–27–1960 Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday Days Months Hours Min. 1 M 2 F 219-80-4576 MD 46 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits BALTIMORE TURNER STATION Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 852 PEACH ORCHARD LANE 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify. Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CUSTODIAN BUILDING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEATRICE MCCULLOUGH TSATAH CLARK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21222 19a. Informant's Name/Relationship (Type. Print) 852 PEACH ORCHARD LANE, TURNER STATION, MD BEATRICE ALLEN/MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State 11/20/07 TRINITY BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F. H., INC Monature of Funeral Service Licenses 1701 LAURENS STREET, BALTO., MD 21217 q 2000 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic neu-small 6.5 cell mon-ths Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State MD

12

**Funeral** 

Director

r 28a-f show notified at

23a must

or items

Department of Health and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or hour any Injury or other traumation.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

Division or Vital

with ber

death

Director

Funeral

þ

Completed

Be

burial-transit and Physician/Medical the as Completed page 2 s

Examiner

þ

Be

P

Certification:

Medical

certificate be executed physician attending properties as ed by the a signed by been certificate l Physician: funeral director this After the Hospital or Attending hin 24 hours after death. the filled in by

within ?

Browner State Registrar

29b. Signature and title of certifier

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

4940

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

MD

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

D-0058893

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Nevember

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Baltomore, MD

28d. Describe how injury occurred

2007 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eastern Avenue All

Hospital:

5 Pending investigation

6 ☐ Could not be

Registrar

State

31. Date filed (Month, Day, 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

07-08630 R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental 1  1- For State Certificate of Death	Reg. No. 2007 3683
Physician/	Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year November 6, 2007  3. Time of Death 1440 hrs
ledical Examiner	4a. Facility Name (that institution, give street and number) 4b. City, Town, or Location of De.	
J.	Johns Hopkins Bayview Medical Center Baltimore	
Funeral Director	2/7-54-2/55 1 M 2 F 3 7 Yrs.	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
any	Usual Residence of Decedent  10a. State, 10b. County 10c. City, Town or Location	10d. Inside City Limits
. 8 1	Md Baltimore Dundalk	1 Yes 2 Mo
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tran 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e. Street and Number 10f. Zip Code 1/8 Ven two Terrale 2/222	US A
r death with or items 23. must be no	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc.
s after de ral", or i niner mu by Fu	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	specify: White
hours a	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	of work done 16b. Kind of Business/Industry retired)
Nore, MD 21215-0036 sges 1 and 2 should be filed within 72 hours a n of Health and Mental Hygiene. Filem 27 is marked other than "natura other traumatic event, the Medical Exami To Be Completed b	Elementary/Secondary (0-12) College (1-4 or 5+)	Cleaner Sanitation
ID 21215-0036 should be filed within and Mental Hygiene. 77 is marked other than natic event, the Medics To Be Compl		ame (First, Middle, Maiden Surname)  a. Mae Langley
2121 ould be fill d Mental I s marked tic event,	19a, Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State, Zip Code)
MD 2 d 2 shou lth and N n 27 is r numatic	Regina Vargas - Daughter 729 S. Luzerne	Avenue, Balto, MS 21224
Baltimore, ME permit. Pages I and 2 si Department of Health an Important: If item 27 injury or other traums	20a: Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Baltimore, pernit. Pages I ar Department of He Important: If ite	4 Donation 5 Other Specify: Dayview Crematory //	-13-67 Malhimore, MD Bradley-Ashfon Funeral Home,
Balt permit. Departi Import injury	21. Signature of Funeral Service Licensee  22. Name and Address & Facility  P. A. 2 / 34 / h) , ///	OU) Shring Rd. 21222
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.	Detween Onset and
:aminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death
1	Sequentially list conditions,  b.	
niner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
usit Examiner	(Disease of Injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
execuing an and all - tra	X UNPENDED AMENDED #23a,27,28a-f, perME,8874, 12/11/07 TT	
	##ZA1,2011, DETTIE, 9074, 12/11/07 11  IF FEMALE:  23c. If yes, outcome of pregnancy	23d. Date of delivery equancy Month Day Year
certifi	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic proposed from the past 12 months?  4 Pregnant at time of death 5 Other (Specify)	egnancy World Bay 1661
Division of Vital Records, P.O. Box 6876 pittal or attending Physician: The law requires that the death certificat ours after death.  Ineral Director: After this certificate has been signed by the attending phittled in by the funeral director, page 2 should be detached for use as the Certification: To Be Completed by Physician/N	1 Yes 2 ✓ No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
P.O. s that th gned by e detach by		1 Yes 2 No 3 Probably 4 Unknown
ds, requires		24a. Was an 24b. Were autopsy findings available prior to completion of cause of
Records, I The law requires fricate has been sig		
tal Reician: The certificate rector, pa	25. Was case referred to medical	
f Vit Physici or this c ral dire	1 V Yes 2 No Impatient 2 Livestipation 6 201	ursing Home 5 Residence 6 Other:  28d. Describe how injury occurred
on on on on the control of the function:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending 11/6/2007 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 X No.	pedestrian struck by auto
ivisior or Attend after death Director: d in by the t	2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division o opptal or Attending hours after death. uneral Director: After y filled in by the fune   Certification:	4 Homicide determined (Specify) street	3300 blk. Fastern Ave. Baltimore, MD
al Fr	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	red at the time, date and place, and due to the cause(s)
To the within To the comple	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	O.C.M.E.	November 7, 2007
Ø	30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MI	D 21201
State	NOO Presidente Cignoture	
Registra	IN MY INDIANCE	

				State of Maryland / D. 3a per dr., g873,	epartment of Health and N Certificate of Death	ental Hygie	
1	Physici	an	1. Decedent's Name (First, Middle, Last)		CHARTIC	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	MARY		HRISTIS	MOVEMBE	
	Examin	er	4a. Facility Name (If not institution, give s	RUXTON	4b. City, Town, or Location of Death		4c. County of Death  BALTIMORE
	Funeral		5. Social Security Number 6. Sex	· · · · · · · · · · · · · · · · · · ·	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birtholace (State or Foreign
	Director		215-14-3275	M 2 F 85	rs. Months Days Hours Min.	(Month, Day, Y) Feb. 3 1	922 MD
	pue *		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town	or Location		10d. Inside City Limits
	Aaryla F sho	ō	MD Baltin				1 Tyes 2 No
	28a-	Funerai Director	10e. Street and Number	TIMON.	10f. Zîp Code	100	g. Citizen of What Country?
	3a or	Ī	660 Straffon Dr. #	<del>/</del> 303	21093	1.03	USA
	death	nera		12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
9	after or Ite	/Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White, etc.
5-0036	urel',	d by	3	Year or Dates:			Specify: white
5	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "neturel", or ltems 23s or 28s-f show imatic event, it e Medical Examinations to retified at	Completed	15. Decedent's Educ (Specify only highest grade	e completed) (	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing 16	b. Kind of Business/Industry
7	withi	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Medical Secretary		Health
פַ	be filed ital Hygie d other event, to	BeC	17. Father's Name (First, Middle, Last)	,		e (First, Middle, Ma	
<u>Jar</u>	Menta Menta Mrked Itic e	ToE	Luther Frampton		Daisy F	aul	
Maryland 2121	2 a a a		19a. Informant's Name/Relationship (Type	the state of the s	Mailing Address (Street and Number or Run		
	s 1 and 3 of Health item 27 other tr	1	Page Christis/daug		Straffon Dr. #303,		
Baltimore,			20a. Method of Disposition 1 ♥ Burial 2 □ Cremation 3 □ Re	emovar nom State	Disposition (Name of crematory or other place) 11/5	/07	c. Location - City or Town, State
≣	그 돈 뿐 글	ļ	' 4 □ Donation 5 □ Other (Specify)  21. Signature of Fune	Dulaney	Valley Memorial Ga	rdens Ti	Lmonium, MD
Ba	permi Depa Impo any it		Mi had	10	Lemmon Funeral Home	of Dular	ney Valley, Inc.
			23a. Part1. Enter the disease, or compile	cations that caused the death. Do no	10 W. Padonia Rd., of enter the mode of dying, such as cardiac	Timonium.	MD 21093 Approximate
В	Physician		shock, or heart failure. List only on Immediate Cause (Final		RENAL FAIL	NOE	Interval Between Onset and Death
E	/Medical		disease or condition resulting in death)	Due to (or as a consequence of)	CCONC FAIL	-0/20	
C	Examiner		Sequentially list conditions b	End Stage Re	nal Disease		
	pe is	Examiner	Sequentially list conditions, I any, isaum to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a sunsequence of			
_	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a consequence of)	)·		
09/	ficate be executed physician and is the burial-transit	caiE			,		
98	ificate g phys as the	edi	d				
ROX	eath certific attending pl	M/U	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death	3 ☐Ectopic pregnancy		23d. Date of delivery
	deat	sicia	in the past 12 months? 1 □ Yes 2 ■ No	4 Pregnant at time of death	5 Other (specify)		Month Day Year
J.	at the de d by the etached	Physician/M	9 Unknown				
Š	The law requires that the death certifica te has been signed by the attending ph age 2 should be detached for use as the	by	Part II. Other significant conditions con-	tributing to death but not resulting in ti	ne underlying cause given in Part I.		cco use contribute to the cause of death?
Ö	w require been si	etec				-	
Hecords,	The law cate has page 2 s	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
Vital	40 CT	မိုင္ပ	25. Was case referred to medical		00 01 10	1 ☐ Yes 2 🗓	
	Physicien: this certificatal director, p	0 8	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outp.	Othor	n <i>(Check only one)</i> me _5 □ Residenc	ce 6 ☐Other (Specify)
וס ר		T: T	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tin	ne of 28c. Injury at	28d. Describe how	
DIVISION	Attending at death. ector: After by the fune	Certification:	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
$\frac{3}{2}$	lor Att	ıţ	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	et and Number of Rural Route Number, State)
	Hospital or 24 hours afte Funeral Dir stely filled in		29a. Certifier 1 Certifying Phys	ician: To the bast of my knowledge	don'th passive of at the time of at a read place.	and due to the same	/->
	e Hos 24 ho e Fun letely	edicai	(Check only one)	eer: On the basis of examination and/of and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occurr	ed at the time, date	and place, and due to the cause(s)
	To the	Me	29b. Signature and title of configer	1	29c. License number	29d.	. Date signed (Month, Day, Year)
1			<b>)</b>	M.D.	D57722	N	WEMBER 1 2007
1	101		30. Name and address of person who cor				
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		LEUNARD RICHARDS	San M.P. 1838	GREENE TREE ROAD	#300	PIKESVILLE MD 21208
	Sta Registra		31. Date filed (Month, Day, Year) NOV 1 9 2007	32. Registrar's Signature	alle)		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM/8, perfyre0373 11/19/07 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician November 13,2007 1:50 P M Davidson James /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Baltimore Towson 8. Date of Birth 8/26/1922 9. Birthplace (State or Foreign (Month, Day, ear) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 26,1922 217-07-2325 85 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it U.S.A. 21236 Funeral 9119 Kilbride Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give1 942 − 1945 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: ò 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Life Insurance Agency Insurance Agent 12 should be filed w h and Mental Hygier ' is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Not Available Davidson John Lerov 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any injury or other trau 9119 Kilbride Road Baltimore, Maryland 21236 Mary Lou Davidson Wife Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11-16-2007 Timonium Maryland 21. Sprature ral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland Taul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirators shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAUS PNEUMOTHER /Medical Due to (or as a consequence of) Examiner FALL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed COLON CANCER 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPIGE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation FALL DOWN STEPS CCTOBER 20,2007 00:00 1 ☐ Yes 2 No Hospital or Attendi thours after death. uneral Director: A death. 25 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 9/19 KILBRIDE RA, BALTINGE, M.O. 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 40ME 24 hours a Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

DANIEUE DOBERMAN.

NOV 1 9 2007

31. Date filed (Month, Day, Year)

111307

Temes

Davidson

32. Registrar's Signature

MO 6565 NEHARLES STREET, SUITE 209, BALTIMOREMS, 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM 2. DEPTHYS . 0873 11 19/07 WS
State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2 0 7 36836 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thelma Jeanette Everett 15,-4:14 A M November /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rock Glen Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 🖫 F 212-48-2641 97 Director Feb. 9, 1910 Maryland Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location ms 23a or 28a-f shor must be notified a 1 AYes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 North Rock Glen Road Items 23a 21229 by Funeral **USA** death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. 3 Widowed 4 □ Divorced 'natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H item 27 is marked oth r other traumatic even Be James L. Marshall ပ Mamie Vermillion 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond M. Lins Nephew 10136 Deep Skies Drive; Laural, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oti 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/17/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Sterling Ashton Schwab Witzke

23. Name and Address of Facility Sterling Ashton Schwab Witzke

Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue; Catonsville, MD 21228

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death ZHEIM Immediate Cause (Final DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lur if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has b irector, page 2 s autopsy performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ∏Yes 2 ∏No neral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year)
November 16, 2007 29b. Signature and title of certifier arkara. D 21649

DHMH 17 Rev 1/2001

State Registrar 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

S. BASKARAN

NOV 1 6

31. Date filed (Month, Day, Year)

se of death (Item 23a) (Type, Print) 3455 W. EKENS AT. Baltimor MD 21229

•			
	Phy /M	sician edical miner	
	⊏Xa	miner	
Division or Vital Records, P.O. Box 68760, 少	or Attending Physician: The law requires that the death certificate be executed after death.	<b>Director:</b> After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Consuella Louise Emile **Physician** 11:197 M NOVEHER 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner SINAT HOSPITAL OF BATTHORE BATAHORE N/A 8. Date of Birth (Month, Day, Year) 9,1919 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M **XX** 88 219-10-8796 Director Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at show MD N/A 14 Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 7 3708 Cottage Avenue 21215 USA Funeral 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. if Health and Mental Hygiene.
Item 27 Is marked other than "natural", or iten other traumatic event, the Medical Examiner. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 🏋 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Vernon Light 9 Elementary/Secondary (0-12) College (1-4or 5+) Caterers Banquet Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Emile Lillian Terrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2nd Fl 19a. Informant's Name/Relationship (Type. Print) Yvonne Harrison/ Niece 706 N. Woodington Rd. Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. Greenmount Cemetery 11/19/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd. Baltimore, MD21215 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. YPERCAPNIC RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) OKSTRUCTIVE PULMONATLY BISONSE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death signed by the attendi 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed PERPENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide filled in within 24 hours a
To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) SINA +COSPITAL OF BARTYWORE Registrar's Signature 31. Date filed (Mo. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vivian McDonald Fisher November 2007 16 7:10a 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fairhaven Sykesville Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Hours 219-30-6143 1 □ M 2 💢 F 99 Dec 11 1907 VA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Carroll Sykesville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) R.B. McDonald Edna Robertson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Blanton (executor) P.O. 4007 Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 11-27-07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Buar P.O. Box 195 Sykesville, MD 21784 MO0764 Hule 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1Pars domentia disease or condition resulting in death) (or as a consequence of): dis case nebrovasular hypertensis Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

**Funeral** 

Director

show

28a-f

ò

23a

, or items

"natural"

marked other

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

d 2 should be fi th and Mental H 7 is marked ott

the Medical filed within Hygiene.

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

Ö

۵.

Division or Vital Records,

pe

Examiner must be notified

Director

Funeral

ð

Completed

Be

2

Examine Physician/Medical þ

and burial-trar physician the as attending use 호 the þ signed by + has page 2 certificate this he Hospital or Attending Pl n 24 hours after death. he Funeral Director: After the pletely filled in by the funeral After t

within 24 State

the

2

Completed Be P Certification: Medical

Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2200 death? 1 ☐ Yes 2 No 1□ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) D34849 November 16 2007

Registrar DHMH 17 Rev 1/2001 1645

Libert

& Ideasy MD 21784

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

3. Registrar's Signature

1 Am

Illiam

31. Date filed (Month, Day, Year,

07-08754	
Herman Fulcott	

erman Fulcott		State of Maryland / Department of Certificate of Registrar		giene Reg.	2007	7 3683
Physici		Decedent's Name (First, Middle,Last)		2. Date of Death	3	. Time of Death
/ledical Exami ⋯`.	ner	nerman bacasta ruicott	4b. City, Town, or Location of Death	Month D November 1	1, 2007 4c. County of Death	1145 hrs
		3806 Fords Lane Apt 102	Baltimore		N/A	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth(	MM/DD/YYYY) 9. Birthp 2, 1950coun	place (State or
Director		217-94-6274   1 3 2 F   57 Yrs		Jan. 2	2, 1990coun	try)Jamaica
v any		10a. State 10b. County 10c. City, Town or Locat Maryland N/A Baltimon			1	0d. Inside City Limits
Maryland 28a-f show d at once.	tor			· · · · · · · · · · · · · · · · · · ·		1XXYes 2 No
MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tean 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Director		10f. Zip Code 21215	109	Citizen of What Country  USA Jan	
V C	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 13. Wa	s Decedent of Hispanic Origin? (Speeds, specify Cuban, Mexican, Puerto I		14. Race - America White, etc.	n Indian, Black,
ffer de	by Fu	1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1	Yes 2 X No specify:		Specify: Bla	ıck
hours a natura Exami	ed b	15. Decedent's Education (Specify only highest grade completed)  16a. Deceder during m	it's Usual Occupation (Give kind of woost of working life, DO NOT use retire	ed)	6b. Kind of Business/Ind	•
136 hin 72 e. than " edical J	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12th grade  Main	tenance Techni	cian M	Mid-Atlant	cic
5-00 led wit tygien other the Me	Con	17. Father's Name (First, Middle, Last)	18. Mother's Name Iris M	115	Realty iden Surname)	<u> </u>
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C					_
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.	2	Patrice Fulcott/Daughter 5023	Address (Street and Number or Ricciosswood Ave	nue Bal	timore, Mc	21 21 4
re, rate		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Crematory or ot	ition (Name of cemetery, ner place)	Date 2	20c. Location - City or To	own, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify:	nt Cemetery 11			
Ball permit Depar Impor		5	Name and Address of Facility Cha 240 Reistersto	tman-Ha wn Rd H	arris Fune Baltimore,	eral Home Md 21215
Physician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.				Approximate Interval Between Onset and
/Medical -xaminer		Immediate Cause (Final disease a. Atherosclerotic cardiovas	scular disease			Death
		Due to (or as a consequence of):  Sequentially list conditions,  b.				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				***
assir de com	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
executed an and al - transit		X UNPENDED X AMENDED #23a,27,perME,g874	+, 12/24/07 TT			
ox 68760, eath certificate be ex attending physician for use as the burial			3,11/17/07,WS		23d. Date of delivery	
certificanting	cian/	23b. Was decedent pregnant in the past 12 months?	tal death 3 Ectopic pregnar	псу	Month Day	y Year
Box e death the atte	Physi	1 Yes 2 No 9 Unknown 9 Unknown	her (Specify)			
ision of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be executed r death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	b	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	2 No 3 Probat	e cause of death?
ords, w require is been sig	Completed			24a. Was an	24b. Were auto	psy findings available
ecol he law ate has age 2 sh	ршо			autopsy performe 1 ✓ Yes 2		npletion of cause of
tal Recions: The certificate ector, page	Be C	25. Was case referred to medical	26.Place of Death (Check or			
Physic Physic er this eral dire	ို	1 Yes 2 No Trospital 1 Inpatient 2 ER/Outpatient		Home 5 Re	esidence 6 Other: S	Scene
on of cading Pheath. or: After the funeral	tion	1 v Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	Edd. Describe not	vinjury occurred	
- L 0 .= -	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street	et, factory, office building, etc.	28f. Location (Stre	eet and Number or Rural	Route Number, City
Div the Hospital or hin 24 hours afte the Funeral Div		4 Homicide determined (Specify)  29a. Certifier 1 Certifier Physician: To the best of my knowledge, death accurate				
	Medical	one) Medical Examiner: On the basis of examination and/or investigate				
	Me	and manner stated.  29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	n, Day, Year)
2		(Cartiskelly)	O.C.M.E.		November 12, 200	7
o bend		Name and address of person who completed cause of death (Item 23a)     Laron Locke MD. Assistant Medical Examiner 111 Penn	Street, Baltimore, MD 2120	1		
		31. Date filed (Month, Day Year) 32. Registrar's Signature	W			

OCME

State of Maryland / Department of Health and Mental Hygienen Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>, 2007 Month **Physician** November 1:48 pmM MABLE SMITHERMAN GILES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Dec 22, 1925 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1□M 2□E North Carolina 81 208-20-0454 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 □Yes 2 □No Director Maryland Prince George's Hyattsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 2 Iner must be n 20783 5800 Peabody Street, Apt. 5 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ral", or iten Examiner 1 Never Married 2 Married 1 ☐ Yes 2**X**No Baltimore, Maryland 21215-0036 Specify: Black <u>À</u> 3XXWidowed 4 ☐ Divorced "natural", Completed er than "natur the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
4 Years Registered Nurse Health Care 7 Is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ada Yates Al Smitherman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8100 Narrow Branch Ct. Gainesville, VA t of Health a Jeffrey Walker 20155 son permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State MD National Mem. PK 11/14/2007 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Name and Address of Eacility Donaldson Funeral Home, P.A. / M00770 Laurel, Maryland 313 Talbott Avenue 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or co plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition resulting in death) MADO **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown by signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1∐ Yes 2 1 Yes 2 No 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manne eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of carrifie pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com 1111 Spring Street 31. Date filed (Month Day, Registrar's Signature Year. State Grant 1 NOV 9

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** VOU 200 16 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner pice owson Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 62 Marylah Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 ☐ No Director mOVR 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 210 No Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) LIGUUY 0 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental 2 oung 19a. Informant S Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) to hel 21206 husban 9 Important: If Item 27 any injury or other tr ames 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State -19-ZOO 7 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility eval Service P.t. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ho Physician ien d /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month 5 Other (specify) P.0.4 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 🗌 No Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ō 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Novamber 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

W.A. Riley

31. Date filed (Month, Day, Year)

NOV 1

G BMC

9

23452.8

Balto, Md Zizox

6701 N. Charles &

32. Registrar's Signature

State Registrar Sinai

32. Registrar's Signature

Hospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

9 2007

Cuona

NOV 1

31. Date filed (Month, Day,

07-08913 Cheryl Rebecca Ha	astin	Please Type or Print in Black Indelible Ink. Ensure All Copie  State of Maryland / Department of Health and Mental Hy	<b>s Are Legit</b> ⁄giene	ole. 200	7 3684
0,,0.,	1- F	For State Certificate of Death	Reg. N	No	3. Time of Death
Physician		Decedent's Name (First, Middle,Last)	2. Date of Death Month Da November 17		1611 hrs
Medical Examine	r /	Decedent's Name (First, Middle, Last)  HEIVI REBECCH  4b. City, Town, or Location of Death		4c. County of Death	
	4a	. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7110 Munford Road Windsor Mill		Baltimore Cou	
	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	Col	hplace (State or Foreign untry)
Funeral Director	J .	714-72-96 72 1 M 2XF 5 2 Yrs. Months Days Hours Min	7-21-19	755	MB
	U:	Sual Residence of Decedent			10d. Inside City Limits
any	10	Da. State 10b. County 10c. City, Town or Location			1 Yes 2 No
and show	ا ة	M& BAITIMORE WINDSOR MILL	10g.	Citizen of What Cour	ntry?
Maryl Maryl date	Director	De. Street and Number		USA	
(69%) ith the Ma		1 Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-		ican Indian, Black,
tems St be a		Armed Forces?	Rican, etc.)	White, etc.	1116
er dez		Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify.			ACH
urs afl tural'	6	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		6b. Kind of Business/	moustry
72 ho	활는	Elementary/Secondary (0-12) College (1-4 or 5+)			
5-0036 lled within 7 Hygiene. d other than	Completed	18.Mother's Nam	ne (First, Middle, Ma	iden Surname)	
	S B	7. Father's Name (First, Middle, Last)  ROSh  HAS+IN95  BEATR	ILE CAI	IAHAN	
2121 ould be fil Mental H marked	의	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, Stat	e, Zip Code)
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and I Important: If iten 27 is n injury or other traumatic	1	BEATRICE HASTINGS 7301 PART FIET	9415 A	20c. Location - City of	r Town, State
e, P. I and I and Healt Fitem	3	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)		BAltimor	
MOF Pages ent of unt: I		4 Donation 5 Other Specify: 6REEN MOUNT CEN	23/07	WEATHE	
Baltimore, MD oemit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	SI BA		mp 21213
	_	Phul BWalleyer 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Physician edical	- 1	failure. List only one cause on each line.			Death
aminer	-	Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerolic cal diovascular disease  Due to (or as a consequence of):			
,		Sequentially list conditions, b.			
	Je.	if any, leading to immediate cause. Enter underlying Cause.			
\V =	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
cuted and transit		d			
Box 68760, edeath certificate be execute the attending physician and ed for use as the burial - tran	Physician/Medical	X UNPENDED #23a.27 perME.g874. 12/24/07 TT		23d. Date of deliv	ery
Box 68760, e death certificate be the attending physic ed for use as the bur	Š	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	Month	Day Year
x 68 h certi lendin use as	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
BO)	hys	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
b, P.O. Beires that the designed by the	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1 Yes		Probably 4 Unknown
S, F quires en sign ald be	fed		24a. Was	an 24b. Were	autopsy findings available to completion of cause of
Division of Vital Records, ral or Attending Physician: The law requir an are dealn. After this certificate has been siled in by the funeral director, page 2 should be lar by the funeral director, page 2 should be a second the secon	Completed			rmed? death	1?
Rec The I icate P	Con	26.Place of Death (Chr			
tal ician: certif	Be	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other   Nt	ursing Home 5	Residence 6 🗸 O	ther: Scene
of Vi Physi er this	٤	1 Ves 2 No 28b. Time of Injury 28c. Injury at Work?		how injury occurred	_
on o nding th. r; Aft	ie ie	1 X Natural 5 Pending			David Number City
iSiC r Atte er dea irecto	ica E	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location or Town,	Street and Number o State)	r Rural Route Number, City
Division of Vital Rec pital or Attending Physician: The ours after death. Teral Director: After this certificate I	Certification:	determined (Specify)		ee/a) and manner as	stated
Hosp 24 ho Fune etely f		29a. Certifier (Check only one)  29a Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	, and due to the cat red at the time, date	e and place, and due	to the cause(s)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed	(Month, Day, Year)
	2	l A		November 18	3, 2007
N. K		- Ideas of person who completed cause of death (Item 23a)			
, John J.		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
	State	31. Date filed (Month, Day, Year)  32 Registrar's Signature			
Regi		NOV 1 9 2007			

DHMH 17 Rev 1/2001 OCME 2006

DHMH 17 Rev 1/2001

		•	For State Registrer	State of Maryland /	Department of Health and Certificate of Death	d Mental Hygier	2001 30043	Ō		
			Decedent's Name (First, Middle, L.	ist)		2. Date of Death	3. Time of Death			
	Physici /Medio		HOWARD	HERO	in SR.	NOVEMBER	-14 2007 1:10 P	М		
	Examin		4a. Facility Name (If not institution, gi	10	4b. City, Town, or Location of De	eath	4c. County of Death			
	, , , ,		5. Social Security Number 6.	Sex 7. Age (In yrs. last bi	mhday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	Balhmore  9. Birthplace (State or Foreign	ian_		
	Funeral Director		218-22-9574	1M 2DF 8		in. (Month, Day, Yea	1926 Country) MI)	gi,		
			Usual Residence of Decedent					=		
	show	-	10a. State 10b. County		m or Location		10d. Inside City Limit			
	Ne M	Director	10e, Street and Number	nore Du	Nda/K 10f. Zip Code	100	Citizen of What Country?			
	with Se or		1.56.9 St 4.6	Na Avenue	2/222	109.	4.50			
	ms 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - American Indian, Black, White, etc.			
9	ours atter death with the Maryla rel', or Items 23e or 28e-f shov Examilied at	Ē.	1 Never Married 2 Married	Armed Forces?  1 V Yes 2 No If Yes, Give	1 Yes 2 No Specify:	ento rican, etc.)	Specify: White, etc.			
21215-0036	72 hours atter death with the Maryland "naturel", or Items 23e or 28e-1 show official Examinational be notified at	d by	3 Widowed 4 Divorced	Year or Dates: WWII		165				
7	in 72	Completed	15. Decedent's 8 (Specify only highest g	ade completed)	<ul> <li>Decedent's Usual Occupation (Give kind of work done during most of vife. DO NOT use retired)</li> </ul>	working 166.	Kind of Business/Industry			
212	filed within Hygiene. ther than "	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Auto Mechanic		ato motive			
	al Hygid I other went, II	Be C	17. Father's Name (First, Middle, Las	0 //	18. Mother's N	Name (First, Middle, Maid	(en Sumame)			
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other than "natural other treumetic event, the Musical	မ	Carl George	Herold	Lillia	N Mae	brendel			
Mar	d 2 sh h and 7 is n treun	i	19a. Informant's Name/Rel Inship	(Type, Print)	D. Mailing Address (Street and Number or	11.	dulemb 21222			
	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. Place (	of Disposition (Name of ery, crematory or other place)	1 100	Location - lity or Town, State			
Ę	0 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	_nemovarion state	1011) ( sema trul 11-	-11,-07 B	alhours MI	,		
Baltimore,	artm artm orte inju	1	21. Signature of Funeral Service Lice	nsee	22. Name and Address A Facility	Bradley - 1	Ashton Funeral	7		
<u>a</u>	Dep Imp eny		Til Kitty		Home, PA, 2134	Willow Spi	ING Rd 21222	2		
			shock, or heart failure. List on	one cause on each line.	not enter the mode of dying, such as card		Approximate Interval Between Onset and Death			
	Priysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 911	WOTIVE PULMONARY	DISEASE	10 YRS			
	Examiner			Due to (or as a consequence	of):					
	1 5 15	Jer	Sequentially list conditions, if a ry, leading to immodiate cause. Enter Underlying Cause (Disease or injury	<ul> <li>Due to (or as a consequence</li> </ul>	υf):					
1/2	nd nd transit	Examiner	that initiated events	C						
8760,	sician and burial-transit		resulting in death) Last	Due to (or as a consequence	of):					
687	ate the	dicai		d						
Box (	eath certific attending p tor use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	205		23d. Date of delivery			
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		Month Day Year			
P.0	that the de led by the detached	Phys	9 Unknown			On Pidashara				
Ś	ires tha signed I be det	by	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	1 2 Yes	co use contribute to the cause of death?  2 □ No 3 □ Probably 4 □Unknov	wn		
Ö	w require been sign should b	etec				24a. Was an	24b. Were autopsy findings availab	nle		
Vital Record	The lav	Completed				<ul><li>autopsy performed</li></ul>	prior to completion of cause of death?	if		
ta		0	25. Was case referred to medical		26. Place of I	1 Yes 2 Death (Check only one)	No 1 ☐ Yes 2 ☐ No			
Ţ	ys dilb	To B	examiner? 1 ☐ Yes 2 ☐ Ño	Hospital: 1   Inpatient 2   ER/O	Other	g Home 57 esidence	6 Other (Specify)			
n of	ng Ph (fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Year)	Time of 28c. Injury at Injury Work?	28d. Describe how in	njury occurred			
isio	ttending F death. tor: After the tunera	icati	2 Accident investigati 3 Suicide 6 Could not	be and Place of Injury - At home f	M 1 Tes 2 No	28f Location (Street	t and Number or Rural Route Number,	_		
Division	or Attend after death Director: /	Certification;	4 ☐ Homicide determine	building, etc. (Specify)	ann, stieet, factory, office	City or Town, St				
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely tilled in by the tune.				e, death occurred at the time, date and pl					
	the Ho lin 24 the Fu	Medical	one)	and manner stated.	nd/or investigation, in my opinion, death o					
	Viith To	2	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)	7		
	1		man you	MID	D62032	No	WEMBIAL 15 200	_		
	JX		30. Name and address of person who	completed cause of death (Item 23a)	DI THERE MAN.	71224				
	Sta	te	31 Date filed (Month, Day, Year)	32 Registrar's Sonature	DANKE THE THE THE THE THE THE THE THE THE TH					
	Registi		NOV 1 9 200	ARREA TO						

∩ ON 07-08873	Jones
UNK UNK	

NK UNK	1	State - For State	e of Maryland /		rtment of tificate of		and Men	ital Hyg	iene Reg.	20	07 3684
Physicia		<del>legistrar</del> 1. Decedent's Name (First, Middle,L	ast)					2.	Date of Death		3. Time of Death
edical Examir	er	Ron		Jone		City To	wn, or Location		Month E November 1	5, 2007 4c. County of De	0000 hrs
		4a. Facility Name (if not institution, g			"	Baltimo		of Death			IA
Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. la	st birthday)	If Under			B. Date of Birth	(MM/DD/YYYY) 9. For	Birthplace (State or eign
Director	L		X M 2 F	21	Yrs.	Months	Days Hour	S IVIIII.	3-7-19	86	Country) Md.
any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits
<b>*</b> .	٦	Md. NA			Baltin	more					1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number		-		10f. Zip C			10g	. Citizen of What C USA	ountry?
th the 1 23a or notifie		4118 Kinsway Av	12. Was Decedent	Ever in III	6 113 Wos		t of Hispanic Or	igin? / Spec	ify Yes or No-		nerican Indian, Black,
eath wi	Funeral	1 XNever Married 2 Marr	Armed Forces?		If Ye	es, specify	Cuban, Mexica	n, Puerto Rio	can, etc.)	White, etc	
after d	by Fi		ed If Yes, Give Year or Dates:		1		No specify			Specify:	Black
hours "natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com				ccupation (Give ing life. DO NO			16b. Kind of Busine	ss/ilidustry
036 ithin 72 ne. r than	Completed	10th grade	NA		Lab	orer				Warehou	seman
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, La Steven	est)	enaul	t			er's Name (F	irst, Middle, Ma	aiden Surname) J	ones
212' uld be Mental marke	o Be	19a. Informant's Name/Relationship			19b. Mailing		(Street and Nu	ımber or Rur		per, City or Town, S	
MD id 2 sho ilth and m 27 is		Myra Sorrell	Si	ster	ı		ora Ave			, Md. 21	213
or Heal		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from Sta	ate C	Place of Disposi crematory or oth	er place)			Date 07	Catonsvi	
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 Other Specal 21. Signature of Funeral Service Li		We	stern S		Cem. Address of Facil		21-07   ch F.H	of the same of the	ite, re-
Bal permi Depa Impo injur	d	& lades	Warre		11	LO1 E	. North	Ave.	Balti	more, Md.	21202
Physician		23a. Part I. Enter the disease, or confailure. List only one cause or		the death.	. Do not enter th	ne mode of	dying, such as	cardiac or r	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and
'Medical aminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Gunsho								Death
•		Sequentially list conditions,	b.		.,.						
	iner	if any, leading to immediate	Due to (or as a conse	equence o	f):						
sit sd K	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	f):						
Sion of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed releath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial—transit	edical	UNPENDED	dAMENDED								
760, cate be physical	/Med	IF FEMALE:	23c. If yes, outcome	me of preg		_				23d. Date of del	
Box 68760, edeath certificate be the attending physic of for use as the bur	ia.	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	time of de	ath =	tal death her (Spec		pic pregnan	су	Month	Day Year
Box te death the att	Physi	1 Yes 2 No 9 Unkn	9 Olikilowii					Dort	23a Did to	hacco use contribut	e to the cause of death?
ires that the signed by	by	Part II. Other significant condition	ns contributing to deat	n but not r	esulting in the t	inaeriying	cause given in	ran i.		2 No 3	
ords, w require s been sig	Completed								24a. Was a		e autopsy findings available r to completion of cause of
of Vital Records, g Physician: The law requir ufter this certificate has been s neral director, page 2 should	dmc	***							perfor	med? dea	th? Yes 2 No
Vital Reco ysician: The law his certificate has director, page 2 s	Be C	25. Was case referred to medical examiner?	III				26.Place of Dea				
f Vit Physic er this c	70 E	1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpati	ent 2	ER/Outpatient		OA Other 28c. Injury at Wo			Residence 6 🗸 (	Other: Scene
ion of tending Pheath.	tion:	1 Natural 5 Pendi	ng Nov 15, 200	Year)	2223 hrs	,,	1 Yes 2	IS	subject sho	t by police	
Division tal or Attendir as after death.	Certification:	2 Accident Invest 3 Suicide 6 Could	not be 28e. Place of I	njury - At h	nome, farm, stre	et, factory,	office building,		or Town, S	tate)	or Rural Route Number, City
Di ospital hours a meral	Cer	4 Homicide determ	1-7-1-77 E0			read at the	time data and			Monúment Streets	
Divisi  To the Hospital or Att within 24 hours after d  To the Funeral Direct completely filled in by	Medical	(Check only 1 Certifying Phyone) 2 Medical Exam	rsician: To the best of B iner:On the basis of exa and manner stated	amination a	and/or investiga	tion, in my	opinion, death	occurred at	the time, date	and place, and due	to the cause(s)
F × F 8	Me	29b. Signature and title of certifier	and mariner stated			290	. License numb	ег			(Month, Day, Year)
<b>9</b> 9		(alumn) O.C.M.E. November 16, 2007							o, 200 <i>1</i>		
		30. Name and address of person v Zabiullah Ali, M.D. A	who completed cause of ssistant Medical E		<sub>n 23a)</sub> r 111 Per	nn Stree	t, Baltimore	e, MD 212	01		
		31. Date filed (Month, Day, Year)	32. Registr		A	de					
Regis	trar	NOV 1 9	2007 heringer	Herman market	w Jan Jan	The state of the s			OCHE		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 8:15 AM Emanuel 2007 enning NOV 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4 St Agnes Health If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1 M 2□ F Yrs. 229-32-3073 4-13-1 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Daltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21216 orna Funeral 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Armed Poices:

1 Des 2 No
If Yes, Give
Year or Dates: Karec-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) abover 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ames enhing 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sister 2202 Mary an 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐ Removal from State Forest Up Flem 20-2007 4 ☐ Donation 5 ☐ Other (Specify) Garrison 11-21. Signature of Funeral Service Licensee Service Mc Culloh Da 1701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Congestive Immediate Cause (Final failure Heart **Physician** Yeons disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Disease Years Coronary Artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 Munknown 1 ☐ Yes 2 ☐ No Completed To the Hospital or Attending Physician: The law requivithin 24 hours after death.

To the Funeral Director: After this certificate has been is 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ⋈ No 24a. Was an autopsy performed? res 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ို 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOV, 14,2007 Punnam, MD

3\*1

Emanae

ennings

State Registrar

DHMH 17 Rev 1/2001

Baltimore, MD - 21229

S. Caton Ave,

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

Jyothi Punnam,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JONES Day Y5 PM **Physician** ovember 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner North WEST Randallstown HOSPITA, BOLTIMORE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 69 1 **X**M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or them. any injury or other trainment. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Tyes 2 □ No Director ma 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 12 Funeral 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ M6 Specify Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2th 18. Mother's Name\_(First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mt ပ 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. 3500 Woodmoor noka m 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 15 ☐ Other (Specify) 3 Removal from State 19/07 Kandaels town, mis, Fre att ILTON Funeral Service Licen mq. march Fitte In Ir to disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate / ause (Final disease or condition resulting in death) Hemorik ubarachnoid **Physician** /Medical Due to (or as a consequence of) Examiner A newlysm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Z Inpatient 2 ☐ ER/Outpatient 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) Court Road, Randalls Town, MD 4 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien® 0.07

		1	For Ama	end #20	State of Marylan Per Verb Jo	d / Depa hns Ho	rtment	of Health 73, 11/1 of Deal	n and N 19/07	lental Hy <b>JH</b>	gienez Reg. No.	007	36849
	Physicia	_	1. Decedent's Name (First, I	Middle, Last)	- Jorda	in				2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic Examin	NO.	4a. Facility Name (If not insti		1		4b. City, T	Town, or Location	on of Death		4c. C	ounty of Death	0,10
e b			Johns Ho 5. Social Security Number	pkins 6. Sex	S Bayvier 7. Age (In yrs.		If Under	1 Year   If Und	der 24 Hrs.	8. Date of Bir (Month, Da	th N	A 9. Birth	place (State or Foreign
	Funeral Director		218-46-988		M 2 F 61	Yrs.	Months	Days Hou	rs Min.	6-14-	1946		ry/and
ī	land ow tf		Usual Residence of Deceder 10a. State 10b. Co		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
	e Mary ka-f she tiffied a	ctor	hd n	1/4	13	altin							1 ☐¥es 2 ☐ No
	with the	Dire	10e. Street and Number 4847 Bou	16	Q 4.10		10f. Zip	120 k				en of What Cou	intry?
	ems 23	Funeral Director	11. Marital Status	1:	2. Was Decedent Ever in U Armed Forces?	.S. 13. \		ent of Hispanic	Origin? (Sp	ecify Yes or No Rican, etc.)		I. Race - Ameri Black, White,	
36	irs after	by Fu	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Dive		1		I∐Yes 2	/				Specify: B/a	ck
21215-0036	72 hou 'natura dical E	eted	15. Dec (Specify only i	edent's Educ	ation completed)	(Give	kind of wor	l Occupation k done during i	most of work	ing	16b. Kind	d of Business/Ir	ndustry
721	within liene.	Completed	Elementary/Secondary (0-	12)	College (1-4or 5+)	ille. L	DO NOT US	orev			Co	ntali	ner
nd	be filed tal Hyg d othel event,	Be	17. Father's Name (First, Mi	ddle, Last)	1			18. M	other's Nam	e (First, Middle	, Maiden S	urname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	ျှ	James 19a. Informant's Name/Rela	ationship (Typ	dah. pe. Print)	19b. Mailir				ral Route Numb	er, City or	<b>1</b> V Town, State, Zi	ip Code)
	and 2 ealth a m 27 Is ner trau		Gerline J	ordan	wife	484		soular		ne. Ba	1to.	Md. Z ation - City or T	CIZOP
nore	ages 1 ant of H t: If Iter y or oth		20a. Method of Disposition  1 ■ Burial 2 □ Crema  4 □ Donation 5 □ Oth		emoval from State	Place of Dispo cemetery, crer	natory or o	ther place)	11-2	4-2007	1Rc.	Ita (	W.
Baltimore,	permit. P Departme Importan any Injur		21. Signature of Funeral Se		1	22	Name an	d Address of F	aclone	العار	Fune	ral Se	ruice KA.
m	S S E S		220 Part Enter the disease	en or compli	Day au	th. Do not ent	er the mod	e of dving, such	loh h as cardiac	or respiratory	NFO. J	led. 21	Approximate
1	Physician	3 9	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition	. List only on	e cause on each line.	tati	c.1	i Ma	Ca	ncer			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	C a.	Due to (or as a conse	quence of):				, (50)			
B		Jer	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	b.	Due to (or as a nonsec	plionaei of):							
	and fin	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.	Due to (or as a conse	quence of):							
8760,	death certificate be executed e attending physician and d for use as the burial-un. til			d	200 10 (01 00 0 00100								
9	ertificat ling phy e as the	Medi	IF FEMALE:		0- 16								
Box	death certific attending p	Physician/Medical	23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No	.nt	3c. If yes, outcome pf pregr 1□Live birth 2□Fet 4□Pregnant at time of	al death 3	∃Ectopic pr ∃ Other <i>(sp</i>				2	3d. Date of deli Month	Day Year
0	w requires that the de been signed by the should be detached	Phys	9 ☐ Unknown  Part II. Other significant co	anditions cor	9Ll Unknown	culting in the u	nderlying c	ause given in F	Part !	23e. Did	tobacco us	se contribute to	the cause of death?
	The law requires that the tte has been signed by thoage 2 should be detache	by	Part II. Other significant of	multions con	inibuting to death but not re-					1.		]No 3□Pr	1
Division or Vital Records,	E 25 C	Completed								24a. Wa	opsy	prior to o	topsy findings available completion of cause of
a R	10 -		25. Was case referred to m	lacibal				00.1	Diago of Doo	th (Check only		death? 1 ☐ Yes	2 <b>X</b> No
Z	Physician: r this certific ral director,	To Be	examiner?		lospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DC	Othori		1 4		□Other (Spec	cify)
o uc	ffe fe			Pending nvestigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 2	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe	how injury	occurred	
Visio	Attending or death. rector: Afte by the fune	Certification:	3 Suicide 6 □ 0	Could not be determined	28e. Place of injury - At I building, etc. (Spec	l nome, farm, st lify)	reet, factor	y, office			(Street and own, State)		ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Cert		rtifying Phys	sician: To the best of my kr		th occurred	at the time, da	ate and place	e, and due to th	e cause(s)	and manner as	s stated.
	he Hos in 24 hc he Fun pletely	ledical	(Check only 2 Me	dical Exami	ner: On the basis of examir and manner stated.	nation and/or in	rvestigation	n, in my opinior	n, death occu	irred at the tim	e, date and	place, and due	e to the cause(s)
	To the Communication of the Co	Ĭ	29b. Signature and title of	ertifier				c. License num				e signed (Mont	H, Day, Year)
,	12		30. Name and address of p	erson who co	ompleted cause of death (Ite	em 23a) (Type,		7/ /// (	1/21			-10-	000/
	12		Willia	m T	HOSEK IN	1)							
*	Sta Regist		31. Date filed (Month, Day,	vear)	1	1 A	3						

State of Maryland / Department of Health and Mental Hygien? 107

36850

			1 - Stata Ragistrar	Cei	rtificate of	Death	Reg	g. No.		
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year		
	Physici /Medio		Young H. Kang				November	14, 2007	6:25 P™	
Exami			4a. Facility Name (If not institution, give street and	d number)		r Location of Death		4c. County of Dea		
			Holy Cross Hospital		Silver			Montgome		
	Funeral Director		5. Social Security Number  213-94-0717  Usual Residence of Decedent	7. Age (In yrs. last birthday)  93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )	9. Bir 1914 Sou	thplace (State or Foreign buntry) th Korea	
	yland now		10a. State 10b. County	10c. City, Town or Lo	ocation			***	10d. fnside City Limits	
	Mary F sh	to	MD Howard	Elkridge					1 ☐ Yes 2 No	
	h the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co		
	th wit		5935 Abrianna Way	Section E	210	175		USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or items 23e or 28e-f show any folury or other traumatic event, the Madical Examinar must be notified at ance.	by Funeral	1 Never Married 2 Married 1 Yes	es 2XXNo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: KI		
Ö	2 hou	Completed by	15. Decedent's Education	16a. Dece	dent's Usual Occup	pation	. 16	6b. Kind of Business	Industry	
215	Madi	ple	(Specify only highest grade comple Elementary/Secondary (0-12) Colle	ge (1-4or 5+) (Give life.	DO NOT use retired	during most of work d)	ing			
2	giene giene	Con	12		emaker			Own Home	3	
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	ŕ		
<u>y</u> a	ould Men varke	2	Kyoung Lim			Unknou		nown		
, Maryland 21215-0036	and 2 sh ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  Jaeho Kang (son)	8231	Ruxton Ci	rossing C1	t., Towso		1204	
Baltimore,	Pages 1 nent of H nt: if Ite iry or otl		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ Removal f  4 ☐ Donation 5 ☐ Other (Specify)	rom State 20b. Place of Disponentery, cremetery, cremetery	matory or other place	ce)	Date 20	oc. Location - City or <b>Timonium</b>		
ä	permit. Departmitmporte		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility RL	ıck Towso	n Funeral	Home, Inc.	
<u> </u>	89889		Super		1050 York	Rd., Tou	uson, MD	21 204		
	m **		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. Do not ent on each line.	ter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between	
September 1	Rhysician		Immediate Cause (Finat disease or condition	Acute Myocardi	al Infarc	tion			Onset and Death	
	/Medical Examiner		resulting in death)	to (or as a consequence of):	_					
Н	Examine:	_	Sequentially list conditions, b.	Ischemic Coli	tis					
	hed	- Ju	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events c.							
	ertificate be executed ing physicien and e as the burial-transit	Examiner	that initiated events c resulting in death) Last							
68760,	sicier b buri	la E								
89	ificate g phy as the	Medical	<u> </u>							
O. Box	The law requires that the death certificate be executed ate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Physiclan/M	in the past 12 months?		□Ectopic pregnancy □ Other <i>(specify)</i>	′		23d. Date of de Month	livery Day Year	
٣.	that led by deta	y P	Part If. Other significant conditions contributing	to death but not resulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?	
rds	tuires n slgn	D D					1 ☐ Yes	2 □ No 3 □ Pi	obably 4 Unknown	
Ö	w require s been sli should t	Completed					24a. Was an	24b. Were at	utopsy findings available completion of cause of	
Be	The iav te hes age 2	E O					autopsy	ed? death?		
<u>ta</u>	an: Tiffica tor, p	0	25. Was case referred to medicaf			26. Pface of Deat	1 Yes 2 h (Check only one)		20110	
<u> </u>	Physician: r this certificanal director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital:	1 ☑Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Oth	05		ice 6 Other (Spe	cify)	
Division of Vital Records, P.O. B	nding Ph ith. :: After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	pate of Injury Month, Day Year) 28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe how	v injury occurred		
Divis	l or Atta efter dez Directo J in by th	Certification:	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm, struilding, etc. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or R. State)	ural Route Number,	
	To the Hospitel or Attanding Physician: The i within 24 hours efter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	(Check only 2 Medical Examiner: On t	o the best of my knowledge, deat he basis of examination and/or in manner stated.	th occurred at the tire	me, date and place, ppinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	s stated. a to the cause(s)	
	To the To the Complex	Σ	29b. Signature and title of certifier		29c. Licens	e number	296	d. Date signed (Mont		
)	<				D65	953		Nov. 15,	2007	
	1		30. Name and address of person who completed							
				10 Forest Glen		ver Sprir	ng, Maryl	and 2091 (	<u> </u>	
市	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 9 2007	2. Registrar's Signature	وخاله					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITEM 23 and 1, 2873, 11 / 19 / 07 WS
State of Maryland 2 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Florie Looch 2007 11 1730p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Hospital Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 ▼ F 64 Director 11-16-1943 214-13-2190 Trinidad Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 Yes 2 No Director Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 129 Farm Road 21001 Trinidad Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married , 0, 1 ☐ Yes 🌠 No Specify. þ 3 Widowed 4 Divorced 'natural", Maryland 21215-00 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Housekeeping Various lst grade NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roopan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rennie Looch Son 129 Farm Rd., Aberdeen, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cem. 11-17-07 Dimdalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Brain henorrabge from Henoraphic /Medical Due to (or as a consequence of): Examine stroke secondary to infective Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit endocarditis Due to (or as a consequence of): Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy o in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1∐ Yes 0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🖎 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGE ISCHARUS

MCMC 500 MPPER CHESAPEAUE DR. BECATE, MD 2/014 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 19 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 16 November **Physician** 2007 Clara Sue Lewis 9:15 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Towson 8. Date of Birth (Month, Day, Year) July 26, 1940 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗙 F 216-36-7846 67 Kentucky Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits F1. Indian River 1 ☐ Yes 2 🗓 No Vero Beach Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2333 Indian River Blvd. #305 32960 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3aftimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Edward Mullins Opal Ludwig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Susan Lewis-Herdegen/ Dtr. 3144 Pyramid Circle Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Co. 11-21-07 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final NUALIAN **Physician** disease or condition resulting in death) 1003 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter processing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Tillnknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) VWS 16 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10 4

State Registr<u>ar</u>

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

WHALKS WW 670 i

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9 2007 Segistrar's Signature

N. Charles ST TONSON MO

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 14, 2007 4:35 a M CHESTER LEE LILLEY 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 715 Maiden Choice Lane, Apt. CC517 Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 3, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maryland 84 218-18-8571 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Baltimore Catonsville Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 715 Maiden Choice Lane, Apt. CC517 21228 12. Was Decedent Ever in U.S. Armed Forces? MXYes 2 □ No If Yes, Give Year or Dates: WWI 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married XX Married 1 ☐ Yes XXNo WWII Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Grade 11 College (1-4or 5+) Carpenter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Morgan Lilley Lily Pugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Maiden Choice Lane, Apt CC517 Catonsville, MD Lorraine Lilley spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cemation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 11/15/2007 Odenton, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Erter the disease, of shock, or heart failure. Lis Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final disease or condition resulting in death) stedle omic Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Residence 6 Other (Specify) No DAS 1 ☐ Yes 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner

physician

The law requires that the death certificate be executed

or Attending Physician:

Hospital

To the

Division or Vital Records, P.O. Box 68760,

**Physician** 

/Medical

**Examiner** 

Director

Funeral

2

Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death v

Pages 1 and 2 should be filed within 72 hours after

al Hygiene. I other than "

n and Mental I

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any liging or other traumatic evone.

Baltimore, Maryland 21215-0036

Examiner Physician/Medical attending properties as ed by the a been signed be should be deta 9 Completed Be After this within 24 hours a er dea h.

To the Funeral Director A completely filled in by the fi

Certification: To

Medical

25. Was case referred to medical examiner?

27. Magner of Death 5 Pending investigation 1 Natural 2 Accident 3 Suicide

6 ☐ Could not be determined 4 Homicide

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature find title of certifier

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed caus of death (Item 23a) (Type, Print)

5 Catanque BALT UND 21225 and 0 19101 31. Date filed (Month, Day, Year)

State Registrar

32 Registrar's Signature

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3	6	8	5	4
$\circ$	V/	$\sim$	~	

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Medical Examiner must be notified at

9		-	1. Decedent's Name (First, Middle, Last)  MINNIE BROWN MARTON  2. Date of Death Month Day Year November 11, 2007						3. Time of Death	
	Physici /Medic		MINNIE BROWN MA			November 11,			5:45 p M	
	Examir		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, o	or Location of Death	4c. County of Death		
		No. of	Morningside House of			Laurel		Prince George		
	Funeral Director		5. Social Security Number 6. Sex 1 M 3	/ /	yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 30	Year) 9. Birt Co , 1912 Was	hplace <i>(State or Foreign</i> <i>untry)</i> hington, DC
	land		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	with the Maryland ia or 28a-f show t be notified at	tor	MD Talbot		St. Mi	chaele				1 X Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number		DC. HI	10f. Zip Code		10	Og. Citizen of What Co	untry?
	h witl 23a o st be	a D	9816 Martingham Circ	le		21663		τ	J.S.A.	
	deat	ner	11 Marital Status 12. W	as Decedent Ever in	n U.S. 1	3. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Ame Black, White	
98	after or its		1 ☐ Never Married 2 ☐ Married 1	∏Yes 2. <b>X</b> No Yes, Give		1 ☐ Yes 2 ☒ No		- 1, o,	Specify:	5, 666.
8	n 72 hours after death w "natural", or items 23a edical Examiner must t	d by		ear or Dates:	10- 0-				Wr	nite
7-	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show. he Medical Examiner must be notified at	lete	15. Decedent's Education (Specify only highest grade com	npleted)	(G. life	cedent's Usual Occu  ive kind of work done e. DO NOT use retire	pation during most of work d)	king	16b. Kind of Business/	industry
212	withi	Completed	Elementary/Secondary (0-12) C	ollege (1-4or 5+) 2		emaker	,		Own Home	
b	should be filed within 72 h nd Mental Hygiene. marked other than "natu matic event, the Medical	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Narr	ne (First, Middle, N	faiden Surname)	
/lar	should be fand Mental I s marked of umatic eve	To E	George F. Brown				Elsie 7	Thompson		
Maryland 21215-0036	e s a	ľ	19a. Informant's Name/Relationship (Type. P	rint)	19b. Ma	ailing Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)
	C = 0 -		Warren Marton /son	la.					chaels, MI	
Baltimore,			20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Remov		cemetery, c	sposition (Name of rematory or other pla	ce)	Date 2	20c. Location - City or	Town, State
ţ	t. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify)		Union (	Cemetery		L7, 07 E	Burtonsvill	.e, MD
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		.00770	22. Name and Addre Donaldson	Funeral	Home, P.	A.	
			23a. Part1. Enter the disease, or complication	ns that caused the d	100773   leath. Do not				Maryland 20	Approximate
	Physician		shock, or lifeart failure. List only one cal Immediate Cause (Final	use on each line.				. ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Cerebral  Due to (or as a con		oosis				Minutes
	Examiner			Septicem					:	Hours
	P ##	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a con	sequence of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c c	Due to (						
60,	be ex ician a burial		,	Due to (or as a con	isequerice oi).					
Box 68760,	eath certificate be executed attending physician and for use as the burial-transit	ian/Medical	d							
X	r certii nding use a	n/Me		yes, outcome pf pre					23d. Date of del	ivery
		icia	in the past 12 months?	☐Pregnant at time		3□Ectopic pregnanc 5□ Other <i>(specify)</i> _	У		Month	Day Year
P.0	Physician: The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached	Physic	9 D OUKHOWII	Unknown			·			
	res the	by F	Part II. Other significant conditions contribu-	ting to death but not	resulting in the	e underlying cause giv	ven in Part I.		acco use contribute to	
oro	w requires is been signer should be	ted						1 1		obably 4 Unknown
3ec	has b	Completed						24a. Was ar autops perforn	y prior to	topsy findings available completion of cause of
a	ician: The certificate ha ector, page		OF Miss are referred to modical					1□ Yes 2	2 XNo 1 ☐ Yes	2 □ No
or Vital Records,	sician: certific irector,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospit	:al: 1 ☐ Inpatient	2 □ ER/Outna	tient 3 DOA Oth		th (Check only one		cify)Assist. Li
Ö	g Physer this eral di	n: To	27. Manner of Death 28	Ba. Date of Injury	28b. Time	of 28c. Inju			w injury occurred	CHY)ASSIST. LI
Division	Attending F r death. ector: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ir) Injur		Yes 2 No			
≥		tific	3 Suicide 6 Could not be 4 Hornicide determined 28	le. Place of injury - A building, etc. (Sp	At home, farm, pecify)	street, factory, office		28f. Location (Str. City or Town	reet and Number or Ri	ural Route Number,
	ital o Irs aft ral Di Iled ir									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: , completely filled in by the f	Medical	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner:	n: To the best of my On the basis of exar and manner stated.	knowledge, de nination and/o	eath occurred at the to r investigation, in my	ime, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	o the vithin of the outle	Mec	29b. Signature and title of contifier	and mariner stated.		29c. Licens	se number	25	9d. Date signed (Mont	h, Day, Year)
	->-0		> Wlean !	T/MA	cea W		W139	16 A	membor	13,2007
	d Ti		30. Name and address of person who comple				VIJI	10 1		-,/
10	人		William A. Warren,	A9	Prince	George S	t. Laurel	, Maryla	nd 20707	
5	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 9 2007	32 Registrar's S	ignature	serles				

			For State	State of M	aryland / Dep			∕lental Hvai	-	36855
			Registrar  1. Decedent's Name (First, Middle	Last)		Tillicate of	Dealli	2. Date of Death		3. Time of Death
	Physici		RENNETT FART, MARTIN Month Day Year							
	/Medic Examir		il inov.						4c. County of Death	5:15 P <sup>M</sup>
	Exami	Ç	CARROLL HOSE	TTAL CENT	ER		INSTER		CARROLI	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday			8. Date of Birth (Month, Day,		place (State or Foreign ntry)
	Director		216-38-4941	1 <b>∑</b> M 2□F	64 Yrs.	World S Days	Hours Will.	10/15/	1943 MARY	LAND_
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Maryl f ehc	jo	MD CAF	ROLL	WESTMI					1 XYes 2 □ No
	1 the	Funeral Director	10e. Street and Number		j	10f. Zip Code		10	g. Citizen of What Cou	intry?
	72 hours after death with the Marylan neturel; or items 23e or 28e-1 ehow Jical Examiner mat be notified at	O IE	182 PENNSYLVA	NIA AVE.	APT. B	211	57		USA	,
	deat deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp		14. Race - Ameri	
9	or its	/Fu	1 X Never Married 2 ☐ Marrie	d 1 ŽŽÝes 2 ☐! If Ýes, Give	№ 1962	1 ☐ Yes 2 No	Specify:	Hican, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland neture!', or items 23e or 28e-f ehow Acal Examiner wast by mailified at	d by	3 Widowed 4 Divorced	Year or Dates:	1966				Specify: WH]	ITE
5	"net	Completed	15. Decedent' (Specify only highest	Education grade completed)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	durina most of work	ring	6b. Kind of Business/In	idustry
12	d within giene.	mc	Elementary/Secondary (0-12) 12	College (1-4or 5	5+)		"CREW CH	TEF	SURVEYORS	3
p	illed Hygi other	BeC	17. Father's Name (First, Middle, L	ast)				e (First, Middle, M		
Maryland	ould be Menta arked atic ev	ToB		ARENCE EA					SE WIRTS	
Mai	d 2 sh th and 7 ie m treum		19a. Informant's Name/Relationsh JERRY MASIMOR						City or Town, State, Zip HAMPSTEAD	<b>—</b> · · · -
	1 an Heal tem 2		20a. Method of Disposition		20b. Place of Disc	osition (Name of	1	Date 2	Oc. Location - City or To	oum State
υO	ages int of th t: If ite y or of		1 ⊠ Burial 2 □ Cremation '4 □ Donation 5 □ Other (Sp	Removal from State	cemetery, cre	matory or other place RANCH CE	e)   M   11/1	9/2007	WESTMINST	יודים אוט
altimore,	permit. Pages Department of Importent: If i eny injury or o		21. Si natus o Fun and Service L	censee	2	2. Name and Addre	ss of Facility $FLI$	ETCHER I	FUNERAL H	OME, P.A.
8	90799				2	54 E. M.	AIN ST.,	WESTM	INSTER, M	
			23a. Part1. Enter the disease, or of shock, or reart failure. List of	omplications that caused nly one cause on each lin	the death. Do not er	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Pnysician	11	Immediate Cause (Final disease or condition resulting in death)	_ a	ardnoic	HVV	ythmias			Onset and Death (dowy
	/Medical Examiner		rosuming in death)	Due to (or as	a consequence of):		/			
		ii	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	uted Insit	Examine	Cause (Disease or injury							
Ć.	exection and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
8760,	cate be executed ohysiclan and the burial-transit			d						
9	rtifica ng phy as th	Medi								
Вох	death certificate be executed e attending physician and ad for use as the burial-transit	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnancy			23d. Date of delive	эгу
	e dea the at ned fo	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∏Pregnant at 9☐ Unknown	_	Other (specify)			Month	Day Year
P. O.	that the de ned by the a detached f				at most recording in the			OG - Didash		
Division of Vital Records,	The law requires that the te has been signed by thoage 2 should be detached.	ed by	Part II. Other significant condition	s contributing to death bi	at not resulting in the t	inderlying cause give	en in Parti.		cco use contribute to the 2 □ No 3 □ Prob	/
000	e law re has bee	Completed						24a. Was an	24b. Were auto	psy findings available
ž	The I	mo						autopsy performe	ed? death?	mpletion of cause of
<u>ita</u>	sien: artifica ctor,	Bec	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)		EE NO
<u>&gt;</u>	hysic his ce	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		nt 3 DOA Othe	er: 4 ☐ Nursing Ho	me 5 🗆 Residen	ce 6 Other (Specify	y)
L C	ding P n. After t funera	00:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time o	of 28c. Injun Work	/ at </td <td>28d. Describe how</td> <td>injury occurred</td> <td></td>	28d. Describe how	injury occurred	
<u>.s</u>	Attending Physicien: r death. ector: After this certific. by the funeral director,	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	AA 6 6		Yes 2 No	005 1		
O	el or A s after of Direct	Certification;	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)							
	hour hour like fill fill fill fill fill fill fill fil	edical (	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of aminer: On the basis of	examination and/or in	h occurred at the tim	re, date and place, pinion, death occurr	and due to the cau	se(s) and manner as st	ated.
	To the H within 24 To the Fi complete	Med	29b. Signature and Mile of certifier	and manner sta	ted.	29c. License			d. Date signed (Month,	
	7		beel	MO			52035		Nov 16	2007
1+1			30. Name and address of person with the control of	no completed cause of de	eath (Item 23a) (Type,	Print) 1 W/2	37mW37	MO 2	1157	
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	and .			//	
	Registra		NOV19	2007	and his fine					

			1 - State Amend #11 Per F	of Maryland / Dep TH G873 11/18	artment of I	Health and M <i>Death</i>	ental Hygio Req	ene g. No. 2007	36856
	Physici /Medio		Decedent's Name (First, Middle, Last)     DALE	ľ	MEYERHOFF	1	2. Date of Death Month NOVEMBER	Day 14 2007	3. Time of Death 10:45A M
	Examir		4a. Facility Name (If not institution, give street and not 2715 JENNER DRIVE APT		4b. City, Town, C	nr Location of Death		4c. County of Death	
- A	Funeral Director	13	5. Social Security Number 6. Sex 1 M 2 √ F	7. Age (In yrs. last birthday		If Under 24 Hrs.	8. Date of Birth (Month, Day, ) 2/05/194	Year) 9. Birthi	place (State or Foreign ntry)
	yland Iow at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	e Marr 8a-f sh ptified	Director	MD N/A	BALTIMOR	- 1				1 Yes 2 No
	a or 2	I Dire	10e. Street and Number 2715 JENNER DRIVE APT.	E	10f. Zip Code 21209		100	g. Citizen of What Coul U.S.A.	*
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12. Was De Armed F	cedent Ever in U.S. 13. Forces? 2 No		dispanic Origin? (Speran, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	can Indian,
15-0	n 72 hc "natu! di al	leted	15. Decedent's Education (Specify only highest grade completed	16a. Dece	edent's Usual Occup e kind of work done	oation during most of workin d)	16 19	6b. Kind of Business/In	dustry
21215-0036	d withii glene. er than the M	Completed	Elementary/Secondary (0-12) College 2	(1-40f 5+)	AGER			RETAIL	
and	be file ntal Hy sd othe event,	Be	17. Father's Name ( <i>First, Middle, Last</i> ) EDWARD	ME <sup>-</sup>	r7	18. Mother's Name	(First, Middle, Ma	aiden Surname)	COHEN
aryla	should nd Mei marke	7	19a. Informant's Name/Relationship (Type. Print)				I Route Number, (	City or Town, State, Zip	
, Ma	and 2 ealth a n 27 is ner trau		VICTORIA RECHES / DAUGH	TER 5904	BERKELEY	AVENUE -	BALTIMOR	RE, MD 2120	
Baltimore, Maryland	nit. Pages 1 artment of H ortant; If iter Injury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	I TRERTY P	osition (Name of ematory or other pla PARK OF LON CONG 12. ame an Addre	11/15	/2007 R	ANDALL STOW	N, MD
Ba	permi Depar Impor any Ir		Roleto / Ju			30	ROAD - F	SON & BROS. PIKESVILLE,	, INC. MD 21208
Y	Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	caused the death. Do not er each line.  CO rong C C Co	ter the mode of dyi	ng, such as cardiac or			Approximate Interval Between Onset and Death
	Examiner			(or as a consequace of):					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Due to Cause (Disease or injury that initiated events	o (or as a consequence of):					
68760,	tificate be executed ig physician and as the burial-transit	edical Exar		o (or as a consequence of):					
Box	w requires that the death certifics been signed by the attending ph should be detached for use as t	Physician/Med	in the past 12 months?	nant at time of death 5	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of deliver	ery Day Year
P.0	hat the	Phys	9 Unknown Part II. Other significant conditions contributing to		inderlying cause giv	ren in Part I	23e Did toba	cco use contribute to the	he cause of death?
ords,	en signe	ed by	dicheles m				1XYes		babiy 4 ☐Unknown
Division or Vital Records, P.O.	i: The law ricate has be	Completed					24a. Was an autopsy performs 1∐ Yes 2	prior to co death?	opsy findings available impletion of cause of 2 ☐ No
Z.	ysiciar s certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐	Inpatient 2   ER/Outpatie	nt 3 DOA Oth	26. Place of Death er: 4 ☐ Nursing Hom	V	ce 6 ☐Other (Specif	6.1
0 0	Ing Ph		27. Manner of Death 1 Natural 5 Pending (Mo.	e of Injury 28b. Time of Injury Injury	of 28c. Injur		8d. Describe how		<i>y</i> /
Divisio	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural City or Town, State)						
	the Hospit in 24 hours the Funera	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and mai	e best of my knowledge, dea basis of examination and/or in nner stated.	th occurred at the tinvestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cau ed at the time, dat	Ise(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the within 2	Σ	29b. Signature and title of certifier Richard C Bay.	Q÷	29c. Licens	e number 20604		d. Date signed (Month,	Day, Year)
2	_		30. Name and address of person who completed cau			wille, 4d 21093	3		
9	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 9 2007						

	For State	State of Maryland		of Health and I		2007 36857		
- ca	Registrar     Decedent's Name (First, Middle)	, Last)	Ochinoatt	, or beaut	2. Date of Death Month	3. Time of Death		
cian Iical	ODETTE		MECI		NOVEMBER			
iner	4a. Facility Name (If not institution SINA) HOSPIT			Town, or Location of Death LTIMDRE C	נדן	4c. County of Death N/A		
ıl r	5. Social Security Number 214-56-8636	6. Sex 1 □ M 2 N F 7. Age (In yrs. last	t birthday) If Under Yrs. Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Y 08/09/19	9. Birthplace (State or Foreign Coupling) MOROCCO		
	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Location			10d. Inside City Limits		
ctor	MD BALT	IMORE BAL	TIMORE			1 □ Yes 2 <b>X</b> No		
Director	10e. Street and Number	0000 11010	10f. Zip		10g	. Citizen of What Country?		
Funeral	16 OLD COURT F	12 Was Docadant Ever in U.S.	13. Was Deced	21208 ent of Hispanic Origin? (Spify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - American Indian,		
To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, spec		o Rićan, etc.)	Black, White, etc.  Specify: WHITE		
eted	15. Decedent (Specify only highes	s Education 1 t grade completed)	16a. Decedent's Usua (Give kind of wor.	Occupation  done during most of work	kina 16	b. Kind of Business/Industry		
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT us	e retired) EMAKER	9	OWN HOME		
Be Co	17. Father's Name (First, Middle,	ast)	110111		e (First, Middle, Ma			
101	JACOB		ENHAMOU	MESSO		SERUYA		
	19a. Informant's Name/Relationsh			(Street and Number or Ru I AVENUE, BA		(ity or Town, State, Zip Code)		
	20a. Method of Disposition 1 ☑ Burial 2 □ Cremation	20b. Plac	ce of Disposition (Nametery, crematory or of	e of		c. Location - City or Town, State		
	4 □ Donation 5 □ Other (Sp	pecify) BA	ALTIMORE HE		<u> </u>	ALTIMORE, MD		
	21. Signature of Funeral Service	icensee				ON & BROS., INC. IKESVILLE, MD 21208		
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that of used the death. I			NAME OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OF THE OWNER OWNER OF THE OWNER OWNE	i		
	Immediate Cause (Final disease or condition		PSIS			Onset and Death		
	resulting in death)	Due to (or as a consequen	nce of):					
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	nce of):					
xamin	Cause (Disease or injury that initiated events resulting in death) Last	C	200.06			- 1		
ш	,	Due to (or as a consequen	ice oi).					
Medic	IF FEMALE:	0.						
Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3□Ectopic pre		23d. Date of delivery Month Day Year			
by Pr	<b>A</b>	ns contributing to death but not resulting		use given in Part I.	23e. Did tobac	co use contribute to the cause of death?		
ted	ATRIAL	- FIBRILLATIO	7		1 ☐ Yes	2 No 3 Probably 4 Inknown		
Completed					24a. Was an autopsy performed 1□ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  ↑No 1 □ Yes 2 ★No		
Be	25. Was case referred to medical examiner?	Hoonitali			h Check onl one	12.100 242.10		
. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury 28	Outpatient 3 DO/ Bb. Time of 28	Other: 4 Nursing Hoc. Injury at Work?	ome 5 Residence	e 6 Other (Specify)		
atior	1 Natural 5 Pending 2 Accident investig	ation	Injury M	Work? 1 ☐ Yes 2 ☐ No				
IF FEMALE:   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic   1   Live birth   2   Fetal death   3   Ectopic   1   Live birth   2   Fetal death   3   Ectopic   4   Pregnant at time of death   5   Other   9   Unknown   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying   A TRIAL   FER/Outpatient   2   ER/Outpatient   3   Ectopic   A   Pregnant at time of death   5   Other   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying   A TRIAL   FER/Outpatient   2   ER/Outpatient   3   Ectopic   A   Pregnant at time of death   5   Other   9   Unknown   Part II. Other significant conditions contributing to death but not resulting in the underlying   A TRIAL   FER/Outpatient   2   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   3   ER/Outpatient   4   ER/Outpatient   3   ER/Outpatient   4					28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)		
Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best of my knowle- examiner: On the basis of examination and manner stated.	edge, death occurred a n and/or investigation,	t the time, date and place in my opinion, death occu	and due to the caus	se(s) and manner as stated. e and place, and due to the cause(s)		
Me	29b. Signature and title of certifier			License number		Date signed (Month, Day, Year)		
	- want dan	MBBS	1	285-000	) NO	IEMBER, 16, 2007		

Registrar
DHMH 17 Rev 1/2001

State

07

OF BALTIMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMIT TALWAK, SINAI HOSPITAL 8

31. Date filed (Month, Day, Year)

2. Registrar's Signature

NOV 1 9 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 10, 2 0 7 **Physician** Eddie Moore November 8:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3641 Reisterstown Road Baltimore N/A 8. Date of Birth (Month, Day, Year) June 10,1922 .Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 247-28-8820 85 Hours June S. Carolina Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD N/A Baltimore Director 1 XYes 2 No 10e. Street and Number 3641 Reisterstown Road 10f. Zip Code 10g. Citizen of What Country? 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black þ Specify: 3XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Bethlehem Steel 8th\_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Moore Fannie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice F. Steele/ Fiance 3641 Reisterstown Rd. Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery 11/15/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd. Baltimore, MD 21215 21. Signature of Funeral Service Licenses Levor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANGESTIVE Due to (or as a consequence of) schemic dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine HYPERTENSION lears Due to (or as a consequence of) **Jedical** IF FEMALE:

Examiner nding physician and use as the burial-tran Division or Vital Records, P.O. Box 68760, signed by the a page 2 To the Hospital or Attending Physician: After thi funeral of

**Funeral** 

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Steila

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of delivery Month Day Year								
ρλ	Part II. Other significant conditions Caucer of the 1		ulting in the underly	ying caus	se given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 □ Unknown			
Completed		_				24a. Was an autopsy performe 1∐ Yes 2∑				
Be C	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
To E	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA	Other: 4 Nurs	sing Home 5 Residence	ce 6 □Other (Specify)			
	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	1	Injury at Work? 1 ☐ Yes 2 ☐ N	28d. Describe how	injury occurred			
Certification	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, f fy)	actory, o	ffice	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)			
dical	29a. Certifier 1 ≥ Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occurrence and/or investig	urred at gation, in	the time, date and my opinion, deat	place, and due to the cause n occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)			

29c. License number

D25663

29d. Date signed (Month, Day, Year)

11/13/07

Registrar DHMH 17 Rev 1/2001

State

711 W.110+3+ BAltimORE, MD 2121

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month rances ,2007 Ree /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3 Droad 8. Date of Birth (Month, Day, If Under 1 Year / If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 8 9 383 -20 1 M 2 L Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 □No Director TOURN 10e. Street and Number 10g. Citizen of What Country? 10106 2/042 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Neyer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Specify: WKITC 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commissioner County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sa ို 510 170 TN+noN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10106 MANIEW000 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-07 umatory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley - ASK ton PA, 2134 WIllow 5 Rd., 21222 DriNG 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1∐ Yes 2 H To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes Certification: To 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Dother (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 🗌 Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Płace of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

9

800

\$2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death NOVEMBER 10, Year NOVEMBER 10, 2007 **Physician** JANE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗗 F Hours Min 83 220-54-8734 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore 1 ☐ Yes 2 ☑ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6806 U.S.A 21212 Trenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced White "natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (#-4or 5+) Educa Item 27 Is marked other other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ၉ HNTTONY POWERS atheriNe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Siskers of Merc 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ō Department of Important: If It any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Wood lawn 4 ☐ Donation 5 ☐ Other (Specify) 11-14-07 21. Signature) of Funeral Service Licensee 22. Name and Address of Facility radley-ASA tON FUNERAL Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PULMONARY EDEMA /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 45 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has bage 2 s autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 X Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated

the

၉

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 1 9 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEHTA.

DHMH 17 Rev 1/2001

ODIGINIAL

Market B

Leala mo

M. D. .

32. Registrar's Signature

29c. License number

7601 OSLER DRIVE.

D 41410

TOWSON.

29d. Date signed (Month, Day, Year)

10

MARYLAND 21204

07-08755
Tammy Parker

Tamr	ny Parker		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  2.0.0.7
	Dhyminic		1- For State Certificate of Death Reg. No. 2007 368  1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death 3. Time of Death
Med	Physicia ical Exami		Tanny Parker November 11, 2007 O735 hrs
			4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
4	\$		Johns Hopkins Bayview Medical Center Baltimore W/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Many) Foreign Many Country) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYYY) 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign Many) Foreign Many Country) 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYYY
	Director	ļ	211-01112-1110
	any	ŀ	Usual Residence of Decedent  10a. State
	nd thow s	_	nd Balto. Dundalc 1 Gres 2 No
	farylar 28a-f aton	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
6	the N 3a or	ä	2716 Dunbrook Ct. apt B 21222 U.S.A.
103	136  In 72 hours after death with the Maryland than "natural", or items 23a or 28a-f show edical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	er dear , or it		1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: White
	urs afte fural" smine	b b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
	72 hou n "nai al Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
	ogf vithin ene. er tha	립	12 4 Administrative Clerk University
	21215-0036  uld be filed within 72 hours I Mental Hygiene. marked other than "natur ic event, the Medical Exami		17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Nancy Hobson
	2121 ald be fi Mental marked c event,	o Be	40- Lifeworth New / Deletinship (Tree Brint)
	e, MD 1 and 2 sho Health and item 27 is r traumation		Richard Parker husband 2716 Dunbrook Ct. apt B Dundalk, Md. 21222
	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene mart of Health and Mental Hygiene than "matural", and it tiem 27 is marked other than "matural", or other traumatic event, the Medical Examiner.	Ī	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,  1 Burial 2 Cremation 3 Removal from State crematory or other place)  20c. Location - City or Town, State
	altimore mit. Pages 1 a partment of He uportant: If it iury or other t		1 Deposition 5 Other Specific Great months of Cremutary 11-11-2007 By/to. Ad.
	Baltimore permit. Pages 1 Department of 1 Important: If	-	21. Signature of Funeral Service Licensee  22. Name and Address of Folity  Carlon C. Dandan  23. Name and Address of Folity  Carlon St. Balto. Md. 21217
		-	23a. Part I. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interva
	Physician /Medical		failure. List only one cause on each line.  Between Onset and  Death
7	-xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Contact gunshot wound of head  Due to (or as a consequence of):
	1		Sequentially list conditions, b
		in	if any, leading to immediate Due to (or as a consequence of):
	DA A	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
	68760, certificate be executed nding physician and	gal	X UNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/9/08 amh
	50, te be e ysiciar burial	ledical	IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Date of delivery
	Box 68760, e death certificate b the attending physical for use as the bu	an/N	23b. Was decedent pregnant in the past 12 months?  23b. If yes, butcome or pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregnancy  Month  Day  Year
	atte	sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown  4 Pregnant at time of death 5 Other (Specify) g Unknown
	D. B the de by the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
	Vital Records, P.O. B ysician: The law requires that the d rist certificate has been signed by the director, page 2 should be detached	ρ	1  Yes 2 ✓ No 3 Probably 4 Unknown
	rds, requir been s	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
	eco ne law te has	E D	performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
	an: Ta	Be	25. Was case referred to medical 26.Place of Death (Check only one)
	Vita hysicii this ce	To B	examiner?  1 Ves 2 No  Hospital: 1 Inpatient 2 VER/Outpatient 3 DOA  Other 1 Nursing Home 5 Residence 6 Other:
	ling P After funera		27. Manner of Death  28a. Date of Injury (Month, Day,Year)  1 Natural 5 Pending 11 (11 (07)  1 Yes 2 X No
	Sion Attend death ector:	cati	la la la la la la la la la la la la la l
	Divi	Certification;	or Town, State) 2/16 Dumbrook Ct, Apt B
	Hospit 24 hour Funcr		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 bours after death.  To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should be	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	F 3 F 3	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			Donna M. Incenti, M.D. O.C.M.E. November 12, 2007
	-0		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
		ate	
	Regis		Marie Marie

State of Maryland / Department of Health and Mental Hygiene 2007 36862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician November 15, 2007 11:00A M Katharine M. Rodgers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Wesley n/a Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H 8. Date of Birth (Month, Day ) 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 906 1 □ M 2 🙀 F Yrs. 220-14-5837 101 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County and Montal Hygiene.
Is marked other than "natural", or items 23a or 28a-f show
raumatic event, the Mudical Experimer must be notified at 10d. Inside City Limits MD Baltimore Freeland 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21626 Parker Road 21053 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married land 21215-0036 1 ☐ Yes 2 No Specify: white Specify: þ 3 Widowed Wivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lucas Brothers 8 Clerk or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John M. O'Hara, Sr. Sarah A. Coughlin Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Important: If Item 27 is any Injury or other trausons. Mary Louise Franklin (daughter) 21626 Parker Road, Freeland MD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) New Cathedral Cem. 11/19/2007 Baltimore, MD. 21. Signature of Funerial Service Lincole 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Maryland 23a. Palt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END-STAGE **Physician** CONGESTIVE ACUTE /Medical Examiner END-STAGE CARDIOMYOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the attending physician and should be detached for use as the burial-transit certificate be executed VALVULAR 1+LARY Due to (or as a consequence of): Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been si, page 2 should t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? INSUFFICIENC 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 🗆 No Vital I Director: After this certific d in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital 1 ☐ Yes 2 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 \ Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge death annured at the time, data and place, and due to the cause(s) and mainter ac stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-19425 who completed are of death (Item 23a) (Type, Print) W. ROGERS AVE - BALTIMORE ROBERT E. M.D -2211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

**ORIGINAL** 

7002

CATH ARING

DHMH 17 Rev 1/2001

			1 - State Amend Item 21	рст п, дол	J, Ce	rtificate of L	Death	R	eg. No.	36863
	Physici		1. Decedent's Name (First, Middle, Last) William Edg	ar Rob	erson			2. Date of Dear Month	Day Yeer	3. Time of Death  2:10 AM
	/Medic Examir		4a. Facility Name (If not institution, give street				Location of Death	, <u>, , , , , , , , , , , , , , , , , , </u>	4c. County of Death	
	Francis		5. Social Security Number 6. Sex	7. Age (In yrs.		BALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	N/A	place (State or Foreign
	Funeral Director		555-18-8411 ¹\\ ™		Yrs.	Months Days	Hours Min.	March 7	Yel920 Mary	land
	and w.w.		Usuel Residence of Decedent  10a. State 10b, County	10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Mary!	tor	Maryland Baltimore	Bal	ltimore	2				1 Yes 2 No
	th the or 28a	Director	10e. Street and Number	1		10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	ath wi		5935 Central Avenu			21207			USA	
980	d within 72 hours after death with the Maryland piene. Ir then "natural", or Itema 23a or 28a-1 show Ite Medical Exactine must be notified at	by Funeral	1 Never Married 2 Married 1	Vas Decedent Ever in U Armed Forces? □ Yes 2 □ No f*Yes, Give /ear or Dates: WW I	'	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:	
20	72 ho	eted	15. Decedent's Education (Specify only highest grade con	n	16a. Deced	dent's Usual Occupa	ition furing most of work	na	16b. Kind of Business/Ir	
21215-0036	within iene. r than "	Completed		College (1-4or 5+)	Mecha	DO NOT use retired,	)		HVAC	
nd	Hygotha ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Surname)	
Maryland	2 should be and Mental is marked a	P	William  19a, Informant's Name/Relationship (Type, F	Roberson			E11a		Blucher	0.4.1
Ma	s 1 and 2 should f Health and Men item 27 Is marka othar traumatic		Karen Rohrer (Daught	*.		•			City or Town, State, $Z_i$	o Code)
altimore,	Pages 1 and 2 nent of Health int: If item 27 inty or other tra		20a. Method of Disposition  1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	20b. P	lace of Dispo cemetery, cren	sition (Name of natory or other place c Cremator on Park	9)	ate	20c.Location · City or T Saltimore, N	
Balti	permit. Pages Department of Important: If i eny injury or once.		21. Signature of Funeral Service Listales	William Berke	22	. Name and Addres	s of Facility Lou		Funeral Ho	
Н			23a. Part1 Enter the disease, or complication shock, or heart failure. List only one ca	ons that caused the deat						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	FAILUR	E	TO T	HRIVE	=	TE	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq			,,		3	WE MON IH
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to or as a conseq	uence of):	-			٥	NE MOR H
	ecuted and -transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to fee and						
68760,	ficate be executed physician and s the burial-transit			Due to (or as a conseq	uence or):					
		ledical	d							
Вох	eath certif attending I for use as	3	IF FEMALE:							
Ö	he dez	ysiclar	in the past 12 months?	yes, outcome of pregna □Live birth 2□Feta □Pregnant at time of d □Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	ss that the deagned by the a	by Physiclan/M	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions contribu	Live birth 2 Feta Pregnant at time of d Unknown	I death 3 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 6 ceat	Other (specify)	in in Part I.	23e. Did tob		Day Year
	requires that the der een signed by the a nould be detached f	by	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions contribu	☐Live birth 2 ☐Feta I☐Pregnant at time of di I☐Unknown	I death 3 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 6 ceat	Other (specify)	n in Part I.		Month	Day Year
al Records, P.O.	law requires that the d as been signed by the 2 should be detached	Completed by	in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions contribu	Live birth 2 Feta Pregnant at time of d Unknown	I death 3 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 6 ceat	Other (specify)		1  Yes 2	Month  acco use contribute to the second sec	Day Year
	law requires that the d as been signed by the 2 should be detached	o Be Completed by	in the past 12 months?  1  Yes 2 No 9 Unknown 9  Part II. Other significant conditions contribut  25. Was case referred to medical examiner?	☐ Live birth 2 ☐ Feta ☐ Pregnant at time of d ☐ Unknown  Iting to death but not resi	I death 3 ⊆ eath 5 ⊆ utting in the ur	Other (specify)	26. Place of Death	1 Yes 2	Month  acco use contribute to the set of the	Day Year the cause of death? pably 4 Nnknown posy findings available mipletion of cause of
	law requires that the d as been signed by the 2 should be detached	To Be Completed by	25. Was case referred to medical examiner?  1 Yes 2 No 9 No 9 No 9 No 9 No 9 No 10 N	☐ Live birth 2 ☐ Feta ☐ Pregnant at time of d ☐ Unknown  Iting to death but not resi	I death 3 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 5 ceath 6 ceat	Other (specify)	26. Place of Death	1  Ye  24a. Was a autops perforr 1  Yes  (Check only on	Month  acco use contribute to the set of the	Day Year the cause of death? pably 4 Nnknown posy findings available mipletion of cause of
	law requires that the d as been signed by the 2 should be detached	To Be Completed by	25. Was case referred to medical examiner?  1	tal: 1 Inpatient 2 Sa. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other  28c. Injury Work M 1 Y	26. Place of Death ir: 4 \( \text{Nursing Hor} \) at ? (es 2 \( \text{No} \)	24a. Was a autops perform 1 Yes 2 (Check only on me 5 Reside 28d. Describe ho	Month  acco use contribute to the service of the se	Day Year the cause of death? pably 4 Ninknown posy findings available mpletion of cause of 2 No
Division of Vital Records, P.O.	law requires that the d as been signed by the 2 should be detached	To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No	The birth 2   Feta   Fe	eath 5 Leath 1	t 3 DOA Other  28c. Injury Work M 1 Y	26. Place of Death ir: 4 \( \text{Nursing Hor} \) at ? (es 2 \( \text{No} \)	24a. Was a autops perform 1 Yes 2 (Check only on me 5 Reside 28d. Describe ho	Month  acco use contribute to the second sec	Day Year the cause of death? pably 4 Ninknown posy findings available mpletion of cause of 2 No
	Hospital or Attanding Physician: The law requires that the d 4 hours after death. Funaral Director: After this certificate has been signed by the ely filled in by the funeral director, page 2 should be detached	Certification: To Be Completed by	25. Was case referred to medical examiner?  27. Manner of eath Natural 5 Pending investigation 3 Suicide 4 Homicide  29. Certifier (Check only 2 Medical Examiner: (Check only 2 Medical Examiner: Check only 2 Medical E	tal: 1 Inpatient 2 Ba. Date of Injury (Month, Day Year)  Be. Place of Injury - At he building, etc. (Specification of the best of my known)	ER/Outpatien 28b. Time of Injury	t 3 DOA Other  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Death If 4 \( \text{Nursing Hor} \) at ? (es 2 \( \text{No} \) b, date and place, i	24a. Was a autops perform 1 Yes 2 (Check only on me 5 Reside 28d. Describe house 28f. Location (St. City or Town	Month  acco use contribute to the second sec	Day Year  the cause of death?  pably 4 Nnknown  posy findings available impletion of cause of the pable of th
	or Attending Physicien: The law requires that the d siter death. Director: Atter this certificate has been signed by the in by the funeral director, page 2 should be detached	To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No   9   Unknown   9    25. Was case referred to medical examiner?  1   Yes   2   No   Hospit  27. Manner of eath   28   28   29   28   29   28   29   29	tal: 1 Inpatient 2 at Ital: 1 Inpatient 2 at	ER/Outpatien 28b. Time of Injury  wiedge, death tion and/or inv	t 3 DOA  Other (specify)  t 3 DOA  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Death  2 \( \text{Nursing Hor} \) at ? es 2 \( \text{No} \) e, date and place, a inion, death occurrence.	24a. Was a autops perform 1	Month  acco use contribute to the second of	the cause of death?  pably 4 Inknown  posy findings available impletion of cause of 24 No  fy) CHRONK  al Route Number,  stated. o the cause(s)  Day, Year)
	Hospital or Attanding Physician: The law requires that the d 4 hours after death. Funaral Director: After this certificate has been signed by the ely filled in by the funeral director, page 2 should be detached	edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No   9   Unknown   9    25. Was case referred to medical examiner?  1   Yes   2   No   Hospit  27. Manner of eath   28   28   29   28   29   28   29   29	tal: 1 Inpatient 2 at Ital: 1 Inpatient 2 at	ER/Outpatien 28b. Time of Injury  wiedge, death tion and/or inv	t 3 DOA  Other (specify)  t 3 DOA  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Death  2 \( \text{Nursing Hor} \) at ? es 2 \( \text{No} \) e, date and place, a inion, death occurrence.	24a. Was a autops perform 1	Month  acco use contribute to the second of	the cause of death?  pably 4 Inknown  posy findings available impletion of cause of 24 No  fy) CHRONK  al Route Number,  stated. o the cause(s)  Day, Year)
	Hospital or Attanding Physician: The law requires that the d 4 hours after death. Funaral Director: After this certificate has been signed by the ely filled in by the funeral director, page 2 should be detached	edical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No   9   Unknown   9    25. Was case referred to medical examiner?  1   Yes   2   No   Hospit  27. Manner of eath   28   28   29   28   29   28   29   29	tal: 1 Inpatient 2 at Ital: 1 Inpatient 2 at	ER/Outpatien 28b. Time of Injury  wiedge, death tion and/or inv	t 3 DOA  Other (specify)  t 3 DOA  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Death  2 \( \text{Nursing Hor} \) at ? es 2 \( \text{No} \) e, date and place, a inion, death occurrence.	24a. Was a autops perform 1	Month  acco use contribute to the second of	the cause of death?  pably 4 Inknown  posy findings available impletion of cause of 24 No  fy) CHRONK  al Route Number,  stated. o the cause(s)  Day, Year)
	Hospital or Attanding Physician: The law requires that the d 4 hours after death. Funaral Director: After this certificate has been signed by the ely filled in by the funeral director, page 2 should be detached	Medical Certification: To Be Completed by	25. Was case referred to medical examiner?  1   Yes   2   No   9   Unknown   9    25. Was case referred to medical examiner?  1   Yes   2   No   Hospit  27. Manner of eath   28   28   29   28   29   28   29   29	tal: 1   Inpatient 2   Section 2   Section 2   Section 2   Section 3   Section	ER/Outpatien 28b. Time of Injury  Dome, farm, structure of the control of the con	t 3 DOA  Other (specify)  t 3 DOA  28c. Injury Work M 1 Y  eet, factory, office	26. Place of Death  2 \( \text{Nursing Hor} \) at ? es 2 \( \text{No} \) e, date and place, a inion, death occurrence.	24a. Was a autops perform 1	Month  acco use contribute to the second of	the cause of death?  pably 4 Inknown  posy findings available impletion of cause of 24 No  fy) CHRONK  al Route Number,  stated. o the cause(s)  Day, Year)

ROBERSON, WICCIAM

07-08835	_	Please Type or Print in Black Indelible Ink. Ensure All Co	
Christopher W. S		otato of Marylana / Bopartment of Floatin and Menta	al Hygiene
		Registrar Certificate of Death	Reg. No. 200/ 3585
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year November 14, 2007  3. Time of Death 0230 hrs
Wedical Exami	ner	Christopher W. Samuelson  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of	
AL.		Washington County Hospital  Hagerstown	Washington
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	
Funeral Director		Months Days Hours	Min. 03/16/1964 Foreign Country) PA
	ŀ		03/10/1904 Cooliny) FA
any	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<b>*</b> .		PA Blair Frankstown Township	1 Yes 2X No
rylan a-f sl	휭	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	R.R. #3 Box 334A 16648	United States
vith th		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	
ath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, I	
fter d		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	Specify: White
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give ki	
72 hc	ete	Elementary/Secondary (0-12) . College (1-4 or 5+) during most of working life. DO NOT u	Concrete
03( Athin ene. rr tha	ompleted	10 Concrete/Mason Spec	
215-0036 be filed within 7 stal Hygiene. Red other than ent, the Medica	ပ		Name (First, Middle, Maiden Surname)
121 d be f ental arket	a		bara J. Chamberlain
D 21 should Ind Mer	٢		er or Rural Route Number, City or Town, State, Zip Code)
, MD and 2 sho ealth and em 27 is	H	Barbara J. Samuelson, Mother R.R. #3 Box 334A,  20a. Method of Disposition   120b. Place of Disposition (Name of cemetery,	Hollidaysburg, PA 16648  Date   20c. Location - City or Town, State
Ore of H.		1 Burial 2 V Cremation 3 Removal from State crematory or other place)	
timent rtant:	- 1	4 Donation 5 Other Specify:	1/17/2007 Baltimore, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Servic Licensee M01113 22. Name and Address of Facility	John C. Bolger Funeral Home
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca	ey Street, Martinsburg, PA 16662 rdiac or respiratory arrest, shock, or heart   Approximate Interval
Physician /Medical		failure. List only one cause on each line.	Between Onset and Death
aminer (		Immediate Cause (Final disease or condition resulting in death)  a. Gunshot Wound of Head  Due to (or as a consequence of):	-
•		h	
	盲	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	Examiner	C. Due to (or as a consequence of):	
rted d ansit		events resulting in death) Last Due to (or as a consequence of):	
executed an and al - transi	g	UNPENDED AMENDED	
68760, certificate be nding physicise as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
387 rtifica ing p	au/		pregnancy Month Day Year
Box (e death ce the attend ed for use	Sici	4 Pregnant at time of death 5 Other (Specify)	
. <b>B</b> C. he de	چ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ģ	Tarti. Other significant conditions	1 Yes 2 ✔ No 3 Probably 4 Unknown
duires en sig	ted		24a. Was an 24b. Were autopsy findings available
OFC aw re- nas be	ompleted		autopsy prior to completion of cause of performed?
Rec The 1	Con		1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital Records,  ng Physician: The law requir ther this certificate has been s' neral director, page 2 should I	Be (	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other;	
Vit	흔	Yes 2 No	Nursing Home 5 Residence 6 Other:
n of \ding Phy. L. After tl		27. Manner of Death  1 Natural 5 Pending NoV 14, 2007 28b. Time of Injury 1248 hrs 1 Yes 2 ✓	Subject shot
Division pital or Attendir ours after death. eral Director: A	ertification:	2 Accident Investigation	
Jivis alor A		3 Suicide 6 Could not be determined (Specify) Parking Lot	. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1008 Security Road, Hagerstown, MD
Spite hours	O	4 Homicae	
Division  To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	g	293. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	
To 1 Vith To 1	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number	29d. Date signed (Month, Day, Year)
	-	0.C.M.E.	November 16, 2007
		Manuell, Mo	
20		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore</li> </ol>	, MD 21201
/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Regis		NOV 1 0 2007	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day William Theodore Stevens 7:53 P M November 16, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** , Year) 1 XM 2 □ F Yrs. 88 Director June 15,1919 Maryland 212-14-0969 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MD Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8414 Foundry Street 20763 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Armed Forces: 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944-46 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1.0 Automobile Industry Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William P. Stevens Margaret Hickey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Stevens 8412 Foundry Street, Savage, Maryland 20763 permit. Pages 1 a
Department of He
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Savage Cemetery Nov 21, 07 Savage, Maryland 21. Signature of Fuperal Service License 22. Name and Address of Facility
Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Ent. th. list se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fallore. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Fine) **Physician** disease or condition resulting in death) Septicemia 2 days /Medical Due to (or as a consequence of): Examiner Pneumonia 8 weeks Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed Empyema 8 weeks burial-tra Due to (or as a consequence of) the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9☐Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Azotemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Clostridium Difficile Colitis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔯 Inpatient 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After t Certification: 1 XNatural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours aft To the Funeral Di 1 \( \) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \( \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signatur and title of certifier 29d. Date signed (Month, Day, Year) TENDING 3005 P4750102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Michael Baako,

31. Date filed (Month, Day, Year)

M.D

9 2007

32 Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

DHMH 17 Rev 1/2001

7300 Van Dusen Road, Laurel, Maryland 20707

		FOI	d / Department of Health and I	Mental Hygien	е	
		1 - State Registrar	Certificate of Death	Reg. N	2007	36866
Physici	an	Decedent's Name (First, Middle, Last)	Stamathis		ay Year	3. Time of Death
/Medi		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	100/1/10/1	2 2007 c. County of Death	16:33PM
Examir	ıer	The Found Hooking Horrital	paltinue City		or obtainly of boarn	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. Is	ast birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Yea	9. Birthp	place (State or Foreign
Director		215-08-730/ 1LM 2151 29  Usual Residence of Decedent	115.	Hugust 2,1	978	MD
ryland how at		10a. State 10b. County 10c. City	, Town or Location		1	Od. Inside City Limits
ne Ma 8a-f s otified	Director		Paltimore City			1 ☑Yes 2 ☐ No
with ti		10e. Street and Number	10f. Zip Code	10g. C	Citizen of What Cour	ntry?
death ims 23 r mus	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	5. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
after or ite		1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ☐ If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	o Rican, etc.)	Black, White,	etc.
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	16a. Decedent's Usual Occupation	16b.	Kind of Business/In	dustry
F15:	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1,4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	rking	11/1	addity
ZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZZ	Com	12 4	N/A		/H	
and d be file ental Hy ced oth c event	Be	17. Father's Name (First, Middle, Last)	18, Mother's Nan	ne (First, Middle, Maide	n Surname)	
aryla should in and Men marke	은	Emmanuel 9. Stamathis  19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Ru	ral Boute Number, City	r a george or Town, State, Ziu	Code)
Mar nd 2 sho alth and 27 is m		Emmayuel Stamathis - father	141 S. LINWOOD Are	Balto.	NA 212	124
IOCE, Maryla ges 1 and 2 should t of Health and Mer If item 27 is marke or other traumatic		20a. Method of Disposition 20b. Pl	ace of Disposition (Name of emetery, crematory or other place)	Date 20c.	Location - City or To	own, State
Saitimor  bermit. Pages Department of i mportant: If it any injury or o		4 □ Donation 5 □ Other (Specify)	Demetrios 11-13	5-07 Ba	14 more	, MD
Baltimol permit. Pages Department of Important: If is any injury or o		21. Signatury of Funeral Service Licensee	22. Name and Address of Facility B	adley - As	d. 2122	
		23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac	or respiratory arrest,	1.,212	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Sock			Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequ	ence of):			3 /
n	ē	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	ence of:			Janys_
Pro outed	Examine	that initiated events				
cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequ	ence of):			
<b>56 / 50</b> ficate be e physician ts the buria	edical	d				
ath certil	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnant			23d. Date of delive	ery
ed for	hysician/Me	in the past 12 months?    1   Yes   2 M No			Month	Day Year
cords, P.O. BOX or we requires that the death certific been signed by the aftending p should be detached for use as	Δ.	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resu	Iting in the underlying cause given in Part I	23e Did tohacco	use contribute to t	he cause of death?
w requires to been signer should be or	d by	3	g			pably 4 □Unknown
ecol law req as beer 2 shou	olete			24a. Was an	24b. Were auto	ppsy findings available
The kate has	Completed			autopsy performed? 1∐ Yes 2⊠N	prior to co death? lo 1 ☐ Yes	mpletion of cause of 2 No
VITAI ician: T sertificat ector, pa	Be	25. Was case referred to medical examiner?		ath (Check only one)		
OF Physi	မ	1		lome 5 Residence		fy)
On ading th. : After funer	tion	1 ⊠ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☐ No	Zod. Describe now Rij	ary occurred	
or Attending frer death. Director: Afte in by the fune	ertification:	and published 6 Could not be	me, farm, street, factory, office	28f. Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	O	29a. Certifier  1 ✓ Certifying Physician: To the best of my know (Check only 2 ☐ Medical Examiner: On the basis of examination				
the H thin 24 the F mplete	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month,	
7 × 0	-	Dal Whitrop MD	R65-000		ember 12,	
6		30. Name and address of person who completed cause of death (Item	23a) (Type, Print)			21287
2		Daniel Gilstrap Johns Hopkins H	Ospidal 600 Worth Wolfe	Street, Bai	Himere, 1	Maryland
Sta Registi		30. Name and address of person who completed cause of death (Item  Danie   G    5   7   9   0   h   1   20     2     1   1    31. Date filed (Month, Day, Year)  12. Registrar's Signar	ture de la company de la compa			/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM/1 per HYS C873, 11/20/07 WS

State of Maryland 7 penalting of Health and Mental Hygiene

Amend Item 23a per dr., 8873, 11/20/07 dbb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Noorjehan Shafi AKA Zumurad 2 Date of Death 3. Time of Death Month **Physician** 09:10 AM HOV 12 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore
If Under 1 Year If Under 24 Hrs.
Hours Min. HIM 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 ■ F Months Days Hours Min. Yrs. 215-76-8411 01 01 Pakistan 60 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Yes 2 □ No Director Baltimore MD NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21236 12503 Dover Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Pakistani 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Beaum Haji Naseer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13632 Mills Farm Road, Rockville, Md 20850 Ibrahin Shafi-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md King Memorial Park 11/12/07 Randallstown, 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21. Signature of Fungral Service Licensee 21215 wette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **1 week** Immediate Cause (Final Sepsis disease or condition resulting in death) Due to (or as a consequence of): 2 years ancer east Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause ol death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 🗷 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No 2 ER/Outpatient 3 DOA

ed by the attending physician and detached for use as the burial-transit aw requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s been signed should be d s certificate has t director, page 2 s

Certification:

**Funeral** 

Director

Itam 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. The Madical Examinar must be notified at

Department of Health a Important: If Itam 27 is any injury or other trains once.

**Physician** 

Examiner

/Medical

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Itam 27 Is marked other then "natural", or Ite

Baltimore, Maryland 21215-0036

with the Maryland

death

27. Manner of Death 5 ☐ Pending investigation 6 Could not be determined

1 Plnpatient 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

М

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner. On the casis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number AU4176435818128

26c. Injury at Work?

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Nov 12 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAGT PREET

Basi

31. Date filed (Month, Day, Year) State

1 Natural

2 Accident

4 | Homicide

3 ☐ Suicide

29a. Certifier

Medical

9 2007

32. Registrar's Signature

22 S. Greene St. Baltimore, MD21201 Courtes

Registrar

Director

ö Hospital

To the

within 24 hours after To the Funeral Dire

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** STEGEMER 10:21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 8. Date of Birth (Month, Day, Year) JULY 12, 1926 Birthplace (State or Foreign Country) If Under Months 5. Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** 1**X**XM 2□ F Days Min. 216.20.6739 81 Director BALTIMORE Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notifled at 1 ☐ Yes ŽŽ No Director LINTHICUM ANNE ARUNDEL MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21090 700 WOODDALE RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 MMarried Maryland 21215-0036 "natural", or 1 Lyyes 2 □ No If Yes, Give Year or Dates1944-1946 Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) than Elementary/Secondary (0-12) WESTINGHOUSE ELECTRICAL ENGINEER 12 should be filed w h and Mental Hygiel 7 Is marked other th 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KATHRINE PHIPPS HENRY STEGEMERTEN SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 470 GOLDEN EAGLE DR., BROOMFIELD, CO 30020 HARY KAY WILDHORN DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAYVIEW CREHATORY INC. BALTIMORE , HD NOV. 16,2007 4 Donation 5 ☐ Other (Specify) 21. Signatur II Funeral Service Licens 24. Name and Address of Facility GREARY FINK FUNERAL HOME, P.A. 1401143 426 CRAIN HUY. S., GLEN BURNIE, ap 21061 comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Part1. Enter the disease, or con shock or heart failure. List only Approximate 23a. Part1 Interval Between Immediate cuse (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Examiner VEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple mycloma with metastatic disease, 23e. Did tobacco use contribute to the cause of death? Records. 9 1 Yes 2 No 3 Probably 4 Unknown Completed bleeding with colon resection 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 1[ Yes Division or Vital Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes within 24 hours after death.

To the Funeral Director; After thi
completely filled in by the funeral 28b. Time of 27. Manner of Ceath 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or A within 24 hours after or To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar 31. Date filed (Month, Day,

29b. Signature and title of certifie

30. Name and

lse of death (Hem 23a) (Type Print)
Harbor Hospital Center, 32. Registrar's Signature

on who completed cay

29c. License numbe

3001 S. Hanover St Baltimore, MD 2

29d. Date signed (Month, Day, Year)

			· iogiotiai	partment of Health and Nertificate of Death	Reg. No. 2	36869
J	Physici		1. Decedent's Name (First, Middle, Last)  RUTH PAULINE TANNER		2. Date of Death 11-15- 2007 Year	3. Time of Death <b>7:30P</b> M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  8413 MERRYMOUNT DRIVE	4b. City, Town, or Location of Death WINDSOR HILL	4c. County of Dea	
	Funeral Director		5. Social Security Number  6. Sex 7. Age (In yrs. last birthda)  1 1 M 2 7 F 102 Yrs.	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Year)	thplace (State or Foreign ountry)
	D	E	Usual Residence of Decedent	ocation	ЈШ.У 12, 1905	VA  10d. Inside City Limits
	Maryla I-f shov fied at	tor		DSOR HILL		Yes 2 No
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 8413 MERRYMOUNT DRIVE	10f. Zip Code <b>21244</b>	10g. Citizen of What Co	ountry?
9800	be filed within 72 hours after death with the Maryland the Hygiene. And Hygiene. And other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes ※ No Specify:	Specify: BL	te, etc. .ACK
21215-0036	within 72 h ene. <b>than "natu</b> <b>ne Medica</b>	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) STIC	ing 16b. Kind of Business	/Industry
_	~ - 0 2	To Be Co	17. Father's Name (First, Middle, Last) ALLEN JONES	18. Mother's Nam	e (First, Middle, Maiden Surname)  IE EDMONDS	·
lary	2 should be and Ments Is marked raumatic events	-		ling Address (Street and Number or Rui		
altimore, ≬	permit Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evonce.		20a Method of Disposition 20b. Place of Disp	ematory or other place) ;	Date 20c. Location - City or	Town, State
Baltir	permit. F Departme Importan any injur once.			22. Name and Address of Facility <b>JA</b>	MES A. MORTON & SO ., BALTO., MD 2121	_
	Cate be executed / Medical Examiner street by the private street is the private street in the private street i	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nter the mode of dying, such as cardiace	or respiratory arrest,	Approximate Interval Between Onset and Death  4 weeks  years  3 months
.O. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Medi		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	elivery Day Year
Records, P.	quires that n signed by Ild be deta	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death? robably 4  □Unknown
II Recoi	The law rec ate has beer page 2 shou	Completed			autopsy prior to performed? peath?	utopsy findings available completion of cause of
Division or Vital	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be	25. Was case referred to medical examiner?  1	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	th (Check only one)  ome 5 Residence 6 Other (Special Courted)  28d. Describe how injury occurred	ecify)
Divis	e Hospital or Attending F 24 hours ofter death. e Funeral Director: After etely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or R City or Town, State)	lural Route Number,
	To the Hospits within 24 hours To the Funera completely fille	Medical C	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, dead one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	rred at the time, date and place, and du	e to the cause(s)
<b>\</b>	To the within 2 To the complete	Me	29b. Signature and title of certifier	29c. License number  00062975	29d. Date signed (Mon	th, Day, Year)
	A		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	10 (1111-117-	410 71000
*	Sta Regist	ate rar	29b. Signature and title of certifier  HUCLAGE  30. Name and address of person who completed cause of death (Item 23a) (Type  Harry Weishaar MD 7360 (W  31. Date filed (Mohth, Day, Year)  NOV 1 9 2007  32 Registrar's Signature	pener	ic rumery ver	-10 -1-13

			For State Registrar	State of Marylan	d / Department of Certificate of		Mental Hygien	7007	36870
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)	treet and number)	OMS 4b. City, Town	n, or Location of Death	2. Date of Death Month Da		3. Time of Death
	Funeral Director	CI	Blue Point  5. Social Security Number  215.60.7161  6. Sex		Hast birthday) If Under 1 Yes  Months Day			9. Birthplac Cautty	ce (State or Foreign
	e Maryland ta-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County  MD	10c. Cit	y, Town or Location  Saltimore			10d	I. Inside City Limits  1 Yes 2 □ No
	eth with th	Funeral Director	5318 BEaufo	rt Aven		215		itizen of What Country U. S. A.	
9036	n 72 hours after deeth with the Maryland "natural", or Itema 23a or 28a-f ehow colical Evantinat must be notified at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Si suban, Mexican, Puert of Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Black, White, etc	
21215-0036	d within 72 giene. rr than "na tre Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use rel School Cros	ne during most of wor rired)	king 16b.	Kind of Business/Indus	E City
Maryland	id be fi ental H ked ot Ic ever	To Be (		ncock		Gert	ne (First, Middle, Maide	) Wiams	
	s f and 2 shou f Health and M frem 27 le mar other traumat		19a. Informant's Name/Relationship (Ty)  Donald Hac  20a. Method of Disposition	K	19b. Mailing Address (Street 1652 &)	Belved	EVE ALE	or Town, State, Zip Co	M) 21239
Baltimore	Page nent o ant: If ury or		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State	Ho Crematory or other p La Crematory @ 22. Name and Ad	hoidon 11	/16/07 T	3elto. M	10
Ba	permit. Departing Imports eny Inje		1 (dyssey)	Thay	ZZZZZ	W. Wersel	AVENUE I	Belta. M.D.	21216
	Physician /Medical		23a. Part1. Enter the disease, of complishock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	enland		Dises		nterval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of).			1	
8760, 🕈	death certificate be executed e attending physicien and d for use as the buriat-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	uence of):				
P.O. Box 68	death certif e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Feta 4 □ Pregnant at time of di 9 □ Unknown	I death 3 Ectopic pregna			23d. Date of delivery Month Da	ay Year
	quires that n signed b uld be deta	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlying cause	given in Part I.	23e. Did tobacco	use contribute to the	N 7
Vital Records,	<ul> <li>The law requires that the icate hes been signed by th</li> <li>page 2 should be detache</li> </ul>	Completed	Dial	eles	ellitu	-	24a. Was an autopsy performed?	24b. Were autops prior to comp death?	y findings available pletion of cause of
of Vit	Physicien: This certificated director, p	To Be	TILI THIS ZID NO		ENOutpatient 3 DOA	Other: 4 Nursing H	ome 5 Residence		
sion (	ting After fune	ation;	27. Manner of Death  1 Natural 5 ☐ Pending  2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)		njury at Nork? ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Division	in Direct	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, factory, offi	ce	28f. Location (Street a City or Town, Sta	and Number or Rural F te)	Route Number,
	in 24 hours and the Funeral in pletely filled	Medical	(Check only 1 Medical Examir one)	ician: To the best of my mo ier: On the basis of examina and manner stated.	wledge, death occurred at the tion and/or investigation, in m	time, date and place y opinion, death occu	rred at the time, date ar	nd place, and due to th	ne cause(s)
-	To the within 2 To the comple	2	29b. Signature Indititle of certifier	Q B-6	29c. Lico	> Z 6	80 290.0	ate signed (Month, Da	2007
	2		30. Name and address of person who co	Porle	Leight	To An	enve	ric.	21215
	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture				

within 24 hours after death. To the Funeral Director: A

completely 3 State Registrar

C NERGARA - SOARES 31. Date filed (Month, Day, Year) NOV 1 9 2007

29b. Signature and title of certifier

anyahrane MD

30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print)

9940 32 Registrar's Signature a College of the State of the S

FRANKLIN SQUARE DR BALTIMORE NO 21236

016619

November 16, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend #1, perMD, g873, 11/19/07 TT Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Satjid Mahmood Walleem Novemba 16 **Physician** 2007 /Medical 4c. Coxinty of Death Rity. Town, or Location of Death 4a. Facility Name (If not institution, give **Examiner** br thwest timene If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours **X** M 2□ F Yrs. **Director** 072-78-8814 Pakistan 02 01 43 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified... once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Reisterstown Directo Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 U.S.A. 78 Trout Brooks Circle Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Aspen Contracting <u>12th\_grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khadija B. Ghulam Qadir ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21136 78 Trout Brooks Circle, Reisterstown, Tahir Ali-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Mag Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Unk Mirpur Kashmir Sector C/4 Mirpur Jamū, 22, Name and Address of Facility of Funeral Service Licenses March F/H West 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the shock, or heart dilure. List only one cause of Immediate Cause (Final sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, C oncrease to tis Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of) Records, P.O. Box 68760 physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Por Month Day Year in the past 12 months? 5 Other (specify) detached 1 ☐Yes 2☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed 1☐ Yes 2☐ Division or Vital Physician: director 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2/2 No 2 ER/Outpatient 3 DOA 1 🗍 Yes Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of (Month, Day Year) Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 TNo death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 1 Medical Examiner: On the basis of examination and/or investigation in a property of the control of the cause of examination and/or investigation in a property of the control of the cause of the cau 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 16, 2007 P4. D completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who ourt Steven FULLER Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 9 200

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g8/3, 11/19/0/dhb 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Tracey Waltman /Medical Eacility Name (If not institution, give street and number, 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 8. Date of Birth (Month, Day, Year) 03.05.1964 Under 1 curity Number Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🖺 F 216.88.9889 43 Director MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6201 Everall Avenue 21206 S.A Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ Your for Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Baltimore, Maryland 21215-003 Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Arnold Pages 1 and 2 should 2 <u>Eillen Dollinger</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trai once. Duane Waltman/husband 6201 Everall Avenune Baltimore MD 21206 et of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 11.09.07 | Beltsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Cremation And Funeal Balto 21. Signature of Funeral Service Licensee gr 8717 Green Pastures Dr. Alternatives MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sever SUPTIN Show /Medical Due to (or as a consequence of): Examiner Pneumonia, Cellulitis Sequentially list conditions, if any, leading to in medical cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a punseouempy of) Examine certificate be executed sician and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a Vital Records, P.O. 9 Unknown the Hospital or Attending Physician: The law requires that the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed: 2 🗆 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3□ DOA Medical Certification: To o funeral c Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Texterifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P g. Jav. MO Resus 11/9/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coo of Sancinia Ball, non 31. Date filed (Manth Day Year) 2007 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year WRIGHT Month **Physician** 6,20 AM OU 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP NIA Kitchie. timore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 M 2 € 216 DORIL 28 Director nare land Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 ☐ No Director 0 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 2 NO Specify þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ecre 1/2 l a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) aryland Be at ricia RIG ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Middle daughler Ambo \aria Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State notro atonsville Crematory 11-17-07 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licengee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of bying, such as cardiac or respiratory arrest, shock, or heart failue. List only one cause on each line.

Immediate Cause (Final) , md, 21229 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 200 carl 1760 disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 I Inknown 9 Onknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2**X** No 1 🔲 Yes 3 Probably 4 Unknown Completed the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 X No 212 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE Hospital: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To his Division or Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) Harnin Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 SOR weph Richa 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 7 DEMAL 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 36875 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05.30 M **Physician** 1 13,200 7 4c. County of Death Facility Name (If not institution, give street and number) \*/Medical **Examiner** nediza onder Birthplace (State or Foreign Country) tv Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 😿 F 70 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 Wes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) avior Health 1276 Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, # once. 17. Father's Name (First, Middle, Last) Be as 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -daught 134 de me 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Keño men.PK 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility m. wa elac ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. 23a. Part T. Enter the dis shock, or heart fall Immediate Cause (Fin-disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Choxnown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ 1 o 24a Was an 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Decliner Other: 4 Nursing Home 5 Residence 6 Other (Specify) pital: 2 N Medical Certification; To 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

3

State

Registrar

DHMH 17 Rev 1/2001

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Yvonne Alleyne 9:26 P Oct. 31, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 9. Birthplace (State or Foreign Country) Guyana, If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 🖾 F 65 Director 578-72-6878 Nov. 13, 1941 South America Usual Residence of Decedent the Maryland a or 28a-f show be notified at 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYes 2 No Maryland Prince George's Kettering 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with ns 23a c must b 10907 Layton Street 20774 USA Funeral "natural", or Items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2K Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant to Physician Samuel W. Alleyne M.D.P.C. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill ent of Health and Mental H It: If Item 27 is marked oth y or other traumatic eventy Be Ernest Sanmoogan Hyacinth Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Samuel W. Alleyne, - Husband 10907 Layton Street, Kettering, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) National Harmony Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 11/5/2007 Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 March 23a. art1. Enter the disease, or a fin lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cardiopulmonary failure /Medical Due to (or as a consequence of) Examiner Pulmonary Embolism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (as as a consequence of): Chronic Renal Failure requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Sarcoidosis Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☒ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' 2 🖾 No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1 🖾 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 State

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Steven Tee, MD 31. Date filed (Month, Day, Year) NOV 0 2 2007

29b. Signature and title of certifier

3415 Hamilton St, Hyattsville, MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

29c. License number

D46998

20782

29d. Date signed (Month, Day, Year)

11/1/2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		for State Registrar		0.00.0		Cer	tificate of	Death		Reg. No.	007	36	277
Physici	ian		e (First, Middle, Las y <b>in Amde</b> m	ariam Are	bad			-	2. Date of Do	eath 20	007 Year	3. Time o	rbeath a <sup>M</sup>
/Medio Examir			f not institution, given	street and number)			4b. City, Town, o Bethesda	r Location of Deat		4c. C	ounty of Death	6:06	a ***
Funeral Director		5. Social Security N 215-53-6	1	`	ge (In yrs. 68	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		<sup>rth</sup> , 1939	9. Birthp	lace (State	or Foreign
land ow tt		Usual Residence of 10a. State	Decedent 10b. County		10c. City	y, Town or Lo	cation				1	0d. Inside C	City Limits
e Mary ta-f she tified a	ctor	MD	Montgome	ry	Sil	Lver Sp	ring					••	s 2 □ No
h with the	al Director	10e. Street and Nut	<sup>mber</sup> .ntford Av	enue			10f. Zip Code 20904			10g. Citize Ethic	on of What Cour	itry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. The profants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Marr 3 □ Widowed	ried 2 X Married 4 □ Divorced	12. Was Decedent Armed Forces 1  Yes 2 If Yes, Give Year or Dates:	?	'	Vas Decedent of H f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or N to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Ethiopian			ı
within 72 ho ene. than "natur he Medical	Completed	(Special Special 15. Decedent's Ed cify only highest gra ondary (0-12)	lucation de completed) College (1-4or	5+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire nal Assis	during most of word d)	rking	10	of Business/Ind	•		
1 and 2 should be flied with Health and Mental Hygiene. Pm 27 is marked other than wher traumatic event, the	To Be Co	17. Father's Name	(First, Middle, Last)			I		18. Mother's Nar Atsede		e, Maiden Si	urname)		
and 2 shot ealth and N n 27 is mai er trauma			ame/Relationship (1 5 Tekle (8			19b. Mailin 735	ng Address <i>(Street</i> Sonata Wa	and Number or Ri ay, Silve	ural Route Num er Spri	ber, City or I .ng,M	Town, State, Zip D 20901	Code)	
Pages 1 and the nent of He nut: If item iny or other			•	Removal from State	Ado	Place of Dispo Demetery over 115 AD 6	sition (Name of metory or other pla Da	сө)	Date 07-2007	20c. Loca Ethic	ation - City or To Opia	own, State	
p+mit. Page Department of Inportant: if any injury or		21. Signature of Ft	uneral Service Licer	A.		- 1	Name and Address 661 Good						e,Inc
Physician /Medical Examiner		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List only (Final on	plications that cause one cause on each l a Due to (or as	ALL.	BLADO		ng, such as cardia	or emoting	arrest,		Approxima Interval Be Onset and 2 4 //	etween
rtificate be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	erlying r injury s	b. Due to (or as		and the second							
	sician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 rgonths? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specify) □ 9 □ Unknown						23d. Date of delivery  Month Day Year			Year		
w requires that the death ce been signed by the attendi should be detached for use	d by Phy	Part II. Other signi	fficant conditions	ontributing to death	but not res	ulting in the u	nderlying cause giv	ven in Part I.		tobacco use	e contribute to t	he cause of bably 4 □	
The law recate has bee	Completed								24a. Wa aut per 1 Yes	opsy formed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings impletion of 2 \square No	s available cause of
s certificate lirector, pag	o Be	25. Was case reference examiner?		Hospital: 1 Nepat	ient 2 🗆	ER/Outpatier	ot 3 DOA Oti	oor.	ath <i>(Check only</i> Home 5 ☐ Rea		Other (See	6.1	
iding Prtysician; The h. After this certificate his funeral director, page	11-1	27. Manner of Dea 1 XNatural 2 Accident	~	28a. Date of Inj (Month, D	ury	28b. Time of Injury	f 28c. Inju Wo		28d. Describe			19)	
or Atter after deal Director in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of in	jury - At he tc. <i>(Specil</i>		reet, factory, office			(Street and own, State)	Number or Run	al Route Nu	mber,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)	1 Certifying Ph	nysician: To the besi niner: On the basis and manner s	of examina	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the	e cause(s) a e, date and p	and manner as s place, and due t	stated. to the cause	e(s)
To th withir To th comp	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month  10-33308  30. Name and address of person with completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month  27d. CTOB FOR 3												
3		1/4	ulor Kr	gono			10-2	3308		OCTO	oben 3	1, 20	
		30. Name and add	ress of person wild	completed cause of	death (Iten	n 23a) (Type,	erint)	c 200	# UIDE	R	PTIFEC		0.00

State Registrar

State of Maryland / Department of Health and Mental Hygiene 7 17 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AYTON November 2007 JOHN SAMUEL Ам 11:28 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY ROCKVILLE
If Under 1 Year | If Under 24 Hrs. ROCKVILLE NURSING HOME 8. Date of Birth (Month, Day, Y April 15 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours Days 1 M M 2□ F 68 Yrs. Maryland 220-34-9052 1939 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 🔀 No Olney Md. Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20832 United States 3916 Brooke Meadow Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 1961— If Yes, Give Year or Dates: 1962 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Ite 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White **∂** 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Forestry Nursery Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be S. Elmer Ayton Blye Story William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trauonce. 3916 Brooke Meadow Lane, Olney, Md. Gloria Jean Ayton / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 11/8/07 Rockville, Maryland Parklawn Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home Box 5038, Laytonsville, Md. 0. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Prostate Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 Z No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after .n 24 hours the Funeral Dir ™ filled ir 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11/02/2007 D0064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 734 Summer Walk Drive, Rockville, Md. Sandeep Sharma, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 05

2007

Elder

				pe or Print in Black					
			1 - For State Registrar	State of Maryland / De	epartment of F Certificate of		ntal Hygiei Reg.		
۲	Physici	an	1. Decedent's Name (First, Middle, Last)	101	-/	2	2. Date of Death	Day Year	Winter of Beath
b.	/Medic	cal	Zdward Bern. 4a. Facility Name (If not institution, give stre		7	or Location of Death		9 2007 4c. County of Death	12:50 FM
				untyltospital	Hagt If Under 1 Year	rs town	Date of Righ	Washi	1 7
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	Hours Min	B. Date of Birth (Month, Day, Ye 2-25-19	ar) 9. Birting Coul	place (State or Foreign
	ow at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town					10d. Inside City Limits
	Ba-f sh	Director	Md. WASHIN	670N HAGE	RSTOWN		140		1 1 Yes 2 □ No
	h with the 23a or 2	al Dir	10e. Street and Number 377 CANNON	AVE	10f. Zip Code	740	10g.	Citizen of What Coul	ntry?
	72 hours after death with the Maryland natural", or Items 23a or 23a-f show dical Examiner must be notified at	Funeral	11. Marital Status 12. 1 ☑ Never Married 2 ☐ Married	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- ican, etc.)	14. Race - Americ Black, White,	
5-0036	ours aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: BL	ACK
72.		Completed	15. Decedent's Educati (Specify only highest grade co	ion 16a. E ompleted) (	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of working d)	7	ON STRU	•
77.7	led within tygiene. her than "	Com	8 71t  17. Father's Name (First, Middle, Last)	College (1-401 5+)	ABORER	18. Mother's Name (			
land	uld be fi fental H rked ot tic ever	To Be	CHARLES t. A	MBUSH		BESSIE			
Mary	12 shout I hand		19a. Informant's Name/Relationship (Type. EOWARD B, AMU		Mailing Address (Street				o Code) N MO 2174
re, l	es 1 an of Healt f Item 2 r other	-	20a. Method of Disposition	20b. Place of I	Disposition (Name of crematory or other pla			Location - City or To	
IIIMOL	it. Page rtment rtant: II njury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses	ioval irom State	tw com.	NOV 6, 3	/	ELDERICK	P
g	perm Depa Impo any i		Say X. Co	lleis		ess of Facility CAR SOUTH ST			
1	<b>∜</b>		23a. Part1. Enter the 1/ ease, or complicat shock, or hear fulure. List only one of immediate Cause (Final	cause on each line.		11	,		Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Maliquant in Due to (or as a consequence of	tracran	//	erten		5days
	Examiner	Į.	Sequentially list conditions, b. –	Span taneo	us intr	acere b	ralh	emorrhage	, 9 days
	executed in and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
/60,	ian uria	-	d	Due to (or as a consequence of	7):				
/ 89 x	The law requires that the death certificate be the has been signed by the attending physicionage 2 should be detached for use as the but	Physician/Medica	IE FEMALE:						
Box	death or attend d for us	ician/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of deliv Month	ery Day Year
J.	uires that the de signed by the a id be detached f	Phys	9 Unknown  Part II. Other significant conditions contrib	9∐Unknown	the underlying cause give	von in Part I	23e Did tobac	co use contribute to t	the cause of death?
rds,	quires t n signe uld be o	Completed by	Hypertension	Adming to doubt put not reculting in	and underlying edded gil		1 ☐ Yes	. /	bably 4 □Unknown
Vital Hecords,	e law require has been si e 2 should b	nplet					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
ta L	siclan: The law certificate has t irector, page 2 s	Be Cor	25. Was case referred to medical			26. Place of Death	performed		2□ No
<u>~</u>	iding Physician: th. After this certifica funeral director, p	2	1 1 1 45 2 2 1 NO	pital: 2 ☐ ER/Outp 28a. Date of Injury 28b. Ti	Patient S BOA		e 5 Residence	e 6 □Other (Speci	fy)
	ath. r: After re funer	ation:	1 Natural 5 ☐ Pending investigation		ury Wo	rk? ]Yes 2 □No	a. Describe now i	njury occurred	
DIVISION	after death.  Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farr building, etc. (Specify)	n, street, factory, office	28	f. Location (Stree City or Town, S	t and Number or Run itate)	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer			ian: To the best of my knowledge,					
	To the H within 24 To the F complete	Medical	one)  29b. Signature and title of Triffier	and manner stated.	29c. Licens	·		Date signed (Month,	
)	P × P 0		1 Holines		159	1392	1	0/29/0-	7
	0		30. Name and address of person who comp	eleted cause of death (Item 23a) (T	ype, Print)				
	Sta		31. Date filed (Month, Day, Year)  NOV 0 5 200	32. Registrar's Signature	Sarle				
	Registi	aı	MUV 0 0 200	CHESCHE JO	1				·

			1 - For Registrar	State of Maryl		rtment of Healt tificate of Dea		ntal Hygiene	(1111)	36880
	Physici /Medic		1. Decedent's Name (First, Middle, L	- 1	obs++		2.	Date of Death Month Day	2007	3. Time of Death
	Examir			ice at The	Lake	4b. City, Town, or Locat  Salist	bury	6		mi co
	Funeral Director		219-34-3769	Sex 7. Age (In 1	yrs. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou		Date of Birth (Month, Dey, Yeer)	9. Birthp Coun	lace (State or Foreign try) land
	show	'n	Usuel Residence of Decedent  10a. State 10b. County		. City, Town or Loc				1	0d. Inside City Limits 1   1 No
	death with the Maryland ime 23a or 28a-f show ime 24a or 28a-f show	Direct	Maryland Wicon  10e. Street and Number  526 G Alabama A		Salisbur	10f. Zip Code 21801			zen of What Cour	8
	or its	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	lf .	/as Decedent of Hispanic Yes, specify Cuban, Mex ☐ Yes 2 □ No Spe	xican, Puerto Ric	v Yes or No-	14. Race - Americ Black, White,	
215-0036		Completed	15. Decedent's (Specify only highest g	Education	(Give k	ent's Usual Occupation and of work done during O NOT use retired)	most of working	16b. Ki	nd of Business/Inc	dustry
and 2121	s 1 and 2 should be filed within it Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me	Be	10  17. Father's Name (First, Middle, Last Frank B. Vetra	0	busine		fother's Name (F	hosp First, Middle, Maiden Anderson	Sumame)	
Maryland	nd 2 should be ilth and Mental 27 is marked o r traumatic eve	ပ္	19a. Informant's Name/Relationship  Joyce a. Grange		E 1/1	Address (Street and Nu Nithsdale I	umber or Rural R	loute Number, City o		Code)
Baltimore,	00-		20a. Method of Disposition  1 XBurial 2 Cremation 3  4 Donation 5 Other (Special Control of Control	☐Removal from State	b. Place of Dispos		10/31/	9 20c. Lo	cation - City or To	
Balti	permit. Pag Department important: I any injury o		21. Signature of Funeral Service Lic	Meney (FS	-Q 22.	Name and Address of F Holloway Fur Holl Snow Hil	acility neral Hoi	me Profes	sional A	ssociation
	Physician / Medical Examiner	licai Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	750	Sequence of):  J.A. 4  sequence of):	•		PS RAS	12	Approximate Interval Between Onset and Death
P.O. Box 6	ie death certific the attending p hed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 SNo 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 □	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P.	w requires that th been signed by should be detacl	þ	Part II. Other significant conditions	contributing to death but not	resulting in the und	derlying cause given in P	art I.	23e. Did tobacco u 1 ☐ Yes 2		ne cause of death?
Œ,	The ate ha	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 X No	prior to con death?	psy findings available inpletion of cause of
of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No		2 ER/Outpatient	3□ DOA Other: 4□		5 Residence		v)
Division	or Attending after death. Director: After in by the fune	Certification:	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide	be Ose Place of Ising	At home, farm, stre	28c. Injury at Work?  M 1 Yes :	2 □No	d. Describe how injur Location (Street an City or Town, State	d Number or Rura	l Route Number,
:	the Hospitei hin 24 hours a the Funeral hpletely filled	Medical C	29a. Certifier (Check only one)  1 Certifying F	Physician: To the best of my eminer: On the basis of exam and manner stated.	knowledge, death nination and/or inve	occurred at the time, dat estigation, in my opinion,	e and place, and death occurred	due to the cause(s) at the time, date and	and manner as si place, and due to	ated. the cause(s)
	Within Compl	Me	29b. Signature and Little of certifier	21 2	(1)	29c. License numb			e signed (Month,	
	Sta	te	30. Name and address of person who CHUAM WAR (Month, Day, Year)  OCT 3 (	S COASTA  32. Registrar's S	HOSPIC ignature	ch fo B	0×173	3 SALis	BURY	-07 us 2/802

DHMH 17 Rev 1/2001

		_ For	Type or Prir State of Ma		Эера	artment of H	lealth a	and N	-		_egible	9.	
		State Registrar			Cer	rtificate of I	Death				200	1	36881
Physicia	an	1. Decedent's Name (First, Middle, La		7 to lo					2. Date of De	eath Day <b>30</b>	Ye	ar 07	3. Time of Death <b>2252 P</b> M
/Medic Examin		John Ric  4a. Eacility Name (If not institution, gi		lthouse		4b. City, Town, or	Location	of Death	10		County of D		2204
Examin	er	Peninsula Regio	1 1/1 1	el Cent	CR	Sales	bury	,		a	licon	arce	1
Funeral Director			Sex 7. Aga 12X M 2 □ F	9 (In yrs. last bii 79	rthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di 2/4/1	ay, Year)	9. <b>P€</b>	Birthpla Countr	nce <i>(State or Foreig</i> n y) ylvania
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation						10	d. Inside City Limits
Maryle f sho ied at	ō	Maryland Wicomi	CO	Sali									1 Mary Yes 2 □ No
r 28a- notif	Directo	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of Wha	t Countr	y?
th with		528L Alabama Av	e.			21801				USA	1		
r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Was Decedent of H f Yes, specify Cuba	ispanic Or an, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, V		
rs afte	by F	1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	Jarry	1	1 ☐ Yes 2 ☑ No	Specify.	:			Specify:	whit	-0
2 houral		15. Decedent's E	ducation		. Deced	dent's Usual Occup	ation			16b. Kir	nd of Busin		
thin 7; e. an "n Medi	Completed	(Specify only highest gas Elementary/Secondary (0-12)	College (1-4or 5	+)	`life. L	kind of work done o DO NOT use retired	during mos d)	st of work	ing	,,,,	177		1
led will lygien ner th		12	-	s	ale	S	10 14-14	ania biana	- /Finch Adiabatic	Į.	yo El	.ect	ricai
ntal H ed otl	o Be	17. Father's Name (First, Middle, Las Elmer Happle Al	,						e (First, Middle Nae Lau				
should and Me mark	ĭ	19a. Informant's Name/Relationship		195	o. Mailin	ng Address (Street	and Numb	er or Rui	al Route Numl	ber, City o	r Town, Sta	te, Zip (	Code)
alth a 27 is 27 is		Susan Lee Gray/d	laughter		404	E. Walnu	t St	., Не	ebron,	MD 2]	.830		J
es 1 e of He of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Removal from State	20b. Place o cemete	f Dispo	sition (Name of matory or other plac	e)		Date	20c. Lo	cation - City	or Tow	n, State
Pag tment tant: I		4 □ Donation 5 □ Other (Spec		Salisk		Cremato	-	11/2			isbur		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If then Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Lice	ensee	0.774.0	22	Name and Address Holloway	ss of Facili Funei	ral I	lome Pr	ofess	sional	As	sociation
		23a. Part1. Enter the disease, or cor	mplications that caused	the death. Do		501 Snow er the mode of dyin					ב עניו		Approximate
Physician		shock, or heart failure. List onl	y one cause on each lir	ne.	, ,	1	4-1	,					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a Due to (or as	a consequence	of):	700	7-11	-				-	
Examiner	_	Sequentially list conditions,	b. —		-0.								
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entire Joseph Cause (Disease or injury	Due to (or as	a consequence	OI):							-	
executed in and ial-transit	Exal	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):								
eath certificate be e attending physician for use as the buria	ical		▲d										
The law requires that the death certificate be the has been signed by the attending physicionage 2 should be detached for use as the bu	Physician/Medical	IF FEMALE:	OCo If was subsame	of assesses									
eath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)	1			2	23d. Date of Month		y Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown										-
w requires that the debeen signed by the should be detached	by PI	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the ur	nderlying cause giv	en in Part	I.			_	te to the	e cause of death?
equire sen siç ould b		ty perter:							1 🗆	Yes 2	No 3[	] Proba	ably 4 Unknown
e law r has be je 2 sh	Completed	Hyper 1-p.den	An						24a. Was	opsy	prio	r to com	sy findings available pletion of cause of
									1□ Yes		dea 1 🗆		No
siciar certif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ②X No	Hospital: 1 Inpatie	est 2 EB/O	utaction	nt 3□ DOA Oth	OF:		h (Check only				
Attending Physician: r death. ector: After this certific. by the funeral director,	<b>⊢</b> i	27. Manner of Death	28a. Date of Inju	ry 28b.	Time of			ursing no	ome 5 Res 28d. Describe			<i>Specily,</i>	<u></u>
ath. or: Aft	atio	1- Natural 5 ☐ Pending investigation	on	y Teal)	injui y		Yes 2□	]No					
or Atte fer de Sirecte n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not determined		ury - At home, fa c. (Specify)	arm, str	eet, factory, office				(Street and		or Rural	Route Number,
To the Hospital or Attend within 24 hours after death. To the Euneral Director:		(Check only 2 Medical Exa	hysician: To the best miner: On the basis o	f examination a									
thin 2 o the gmple	Medical	29b. Signature and little of certifier	and manner sta	ated.		29c. Licens	e number			29d. Dat	e signed (A	Month, E	Day, Year)
= 3 = 1K						1700	554	170	,	101	11-5		
STAN		30. Name and address of person who	o completed cause of d	eath (Item 23a)	(Type,	Print)	-/ (		(———	///	112/		
J. Na	`	Greg Treath	100 €.	AIRII S	7.	3AL1564	ky, 1	no					
Sta Registr		30. Name and address of person who fing Trush 31. Date filed (Month, Day, Year)  NOV 0 2	2007 32. Project	ar's Signature	1	hart's							
negisti NHMH 17 Bay 1/20		1404 0 %	2001	, JC.	17								

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36882

instopher reju		Penietrar	ficate of Death	Reg. No.	
Physicia	an/	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day Year November 9, 2007	3. Time of Death 0323 hrs
<sup>⊬' ⊲</sup> ical Exami		Christopher Ryan Borst  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		
		49 Geiser Way	Smithsburg	Washingto	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		<del></del>	9. Birthplace (State or Foreign California
Director		171-70-6535 1XM 2F 26	Yrs. Months Days Hours M	Feb. 11 1981	Country)
any	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location		10d. Inside City Limits
* .		Maryland Washington	Smithsburg		1 Yes 2 XNo
Maryland 28a-f show	Director	10e. Street and Number	10f. Zip Code 21783	10g. Citizen of What	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tenth and Mental Hygiera them 17 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		49 Geiser Way	S.A		
h with the n	Funeral	11. Marital Status  1 X Never Married 2 Married 12. Was Decedent Ever in U.S Armed Forces?	<ul> <li>13. Was Decedent of Hispanic Origin? (</li> <li>If Yes, specify Cuban, Mexican, Puer</li> </ul>		American Indian, Black, etc.
er dea , or it	Fur	Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify:	White
hours afte 'natural'', Examiner	ğ	or Dates:	16a. Decedent's Usual Occupation (Give kind o		ness/Industry
72 hou "ua"	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r		.
21215-0036 uld be filed within 72 Mental Hygiene. marked other than '	ompl	2	Student		llege
filed v Hygi d oth	၂ပေျ	17. Father's Name (First, Middle, Last)	18.Mother's Na	me (First, Middle, Maiden Surname) Christine P. Lew	and oucki
212 ould be Menta marke ic even	To Be	Brian M. Borst  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number of		
e, MD 21215-003 and 2 should be filed withi Health and Mental Hygiene. item 27 is marked other th	-	Brian M. Borst - father	5801 Stone Bridge	Road Greencastle	. PA 17225
rre, MD 3 s 1 and 2 shoi of Health and If item 27 is		20a. Method of Disposition 20b. P	lace of Disposition (Name of cemetery, rematory or other place)	Date 20c. Location - C	City or Town, State
imore, MD 2121 Pages 1 and 2 should be finent of Health and Mental 1 and: I fiten 27 is marked or other traumatic event,		4 Donation 5 Other Specify:	thsburg Crematory 11	A CHARLEST ON SECTION	burg Maryland
Baltimore, permit. Pages l an Department of Hea Important: If iter injury or other tr		21. ature of Funeral Service Licensee	22. Name and Address of Facility		
	14	23a. Part I. Ent. The disease, or complications that coused the death.	1331 Eastern Blvd		
Physician /Medical		failure. Lift only one cause on each the.			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Narcotic (morphia Due to (or as a consequence of Due to	:		
		Sequentially list conditions, b.			
	ine	if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	i:		
ws g tw	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	:		
xecuted and ransit		d			
'60, rate be execut obysician and he burial - tra	Medical	X UNPENDED AMENDED #23a, PII, 27, 28a-	f, perME,g874, 12/3/07 TT	23d. Date of c	delivery
876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic pre		Day Year
Box 687 ne death certific the attending part for use as the	Physician/	4 Pregnant at time of dea	other (Specify)		
D. BC trthe dea by the a	Ph.	Part II. Other significant conditions contributing to death but not re	sulting in the underlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
j, P.O. E ires that the d signed by the	þ	Pulmonary hypertension; diabetes n		1 Yes 2 🗸 No 3	Probably 4 Unknown
ords, w require is been si should b	Completed				/ere autopsy findings available rior to completion of cause of
cor e law r e has t ge 2 sh	du	<u> </u>		performed? de	eath?  Yes 2 No
Rec n: The l tificate b		25. Was case referred to medical	26.Place of Death (Che		100 2 100
Vital   ysician: his certifi director,	o Be	evaminer?	ER/Outpatient 3 DOA Other Nu	rsing Home 5 Residence 6	Other: Scene
of Vital Recoling Physician: The law After this certificate has		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre	ed
ion ttendi teath. ttor: /	atio	Natural 5 Pending Fnd 11/9/2007	unk 1 Yes 2 X No	unk	Dural Dural Mumber City
Division of Vital Records, tal or Attending Physician: The law require as after death.  Director: After this certificate has been sided in by the flueral director, page 2 should b	Certification:	3 Suicide 5 X Could not be	ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Town, State)	
Division  Hospital or Attent 24 hours after death Funeral Director: stely filled in by the		4 Homicide determined (Specify) Home  29a. Certifier Check only  1 Certifying Physician: To the best of my knowledge	no death occurred at the time, date and place	49 Geiser Way Smit	
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination at	nd/or investigation, in my opinion, death occurr	ed at the time, date and place, and di	ue to the cause(s)
To wit	₩ W	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signe	ed (Month, Day, Year)
		( ) Cantalacuso	O.C.M.E.	November	9, 2007
	1	30. Notifie and address of person who completed cause of death (Item		1	
		Laron Locke MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 2	21201	
Regis	itate	31. Date filed (Month, Day Year) 2007 32 Registrar's Signate	tre January		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** November 1, 2007 George Brees 1:40 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 01ney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye April 9, 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Year New York Months Days Hours 1 ☑ M 2 □ F 91 090-05-3620 **Director** Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d Inside City Limits 10a. State 10b. County r 28a-f show notified at MD Montgomery Silver Spring 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number p e 15310 Pine Orchard Drive Apt 2G 20902 United States ral", or items 23a Examiner must b Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23ary or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4or 5+) Computer Analyst US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathan Brees Gussie (Unascertainable) ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15310 Pine Orchard Drive Apt 2G Silver Spring MD Sally D. Brees - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Memorial Grdns 11/2/2007 Olney, MD 4 Donation 5 Dother (Specify) 21. Signature of Euperal Sc Licenson -22 Name and Address of Facility Figure 3 age 1 Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician an s the burial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as t attending | IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 ☐ Ectopic pregnancy Month Year 5 ☐ Other (specify) signed by the a 2 □ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate has rector, page 2 autopsy 1∐ Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Hipatient 2 ER/Outpatient 3 DOA this 27. Manner of eath 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director:.
completely filled in by the f 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of/cettifier 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) NOV 0 2 2007 32. Jegistrar's Signature

30. Name and address of person who completed cause of death (item 23a) (Type, Print)



MD 18101 Prince Philip Drive Olney MD 20832

		4	State	State of Maryland		irtment of H			ene 200	7 36884
			Registrar  1. Decedent's Name (First, Middle, Last)		007	imodic or i	Joann	2. Date of Death	·g. 110.	3. Time of Death
75	Physicia						Month	Day Ye	8:27 A M	
-	/Medic	al	Florence Olivia	4h Cihi Touri or	Location of Death	0ct. 3	0, 2007	0.27		
	Examin	er	4a. Facility Name (If not institution, give str							gomery
A.C.	<u></u>		Holy Cross Hospita	7. Age (In yrs. I	act hirthday)	If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign
	Funeral		1 🗆 N	1 2X F 7. Age (117)13. 1	Yrs.	Months Days	Hours Min.	Month, Day, June 25	Year)	Country) ennsylvania
	Director	-	282-32-0633 Usual Residence of Decedent	, ,			1	June 25	,1930 11	omoy ivania
	land ow		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary -f sh	to	D.C. None	Wa	ashing	ton, D.C.				1 X Yes 2 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of Wha	at Country?
	3a o	0	5420 Conn. Ave., N.	W.		200	015		USA	
	ms 2	Jer		. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		American Indian, White, etc.
9	after or ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 📉 No If Yes, Give		1 □ Yes 2 🗓 No	Specify:	Thous, oral,		White
215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dikal Examiner must be notified at	b b	3 X Widowed 4 ☐ Divorced	Year or Dates:		••				
5-0	72 ho natu dical	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	dent's Usual Occup kind of work done	during most of work		16b. Kind of Busir	ness/Industry
7	ithin ne.	d l	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	1)		Self-Emp	Joved.
21	ygier ygier ner th			3	WI	riter	18. Mother's Nam			TOYER
Maryland	be fil Ital H id oth	Be	17. Father's Name (First, Middle, Last)  Bertram Weil				Dorothy	- 1	naloon camaine)	
<u>\sq</u>	ould Mer narke	မှ			405 Maille	ng Address (Street	-		City or Town St	eta Zin Coda)
Jar	2 sh and Is m		19a. Informant's Name/Relationship (Type	e. Print)						
<u>(</u>	and lealth m 27 her t		David Baker/Son	20h P	Place of Disno	Clark St.			20c. Location - Ci	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State	emetery, crei	matory or other place itan	Nov.	1.		•
Ē	tant:		4 □ Donation 5 □ Other (Specify)		remato	ry	; Z	007	17	ia, Virginia
Sall	permit Depar Import any in		21. Signature of Funeral Service Firm	1/2		2. Name and Addre				DC 20007
	<u> </u>		sollute 1	py						on,DC 20007  Approximate
			23a. Part . Enter the disease, or complications shock, or heart failure. List only one	cause on each line.	n. Do not en	ter the mode of dylr	ng, such as cardiac	or respiratory arri	est,	Interval Between Onset and Death
¥	Physician		Immediate Cause (Final disease or conditiona.	Dementia						
	/Medical Examiner		resulting in death)	Due to (or as a conseq						
١.	Examine	_	Sequentially list conditions, b.	Diabetes Ty	pe 2					
2	pe tis	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
$\mathcal{D}$	and -trans	Kam	that initiated events resulting in death) Last	Hypertension  Due to (or as a conseq						
90,	cate be executed oblysician and the burial-transit	E		Dag to for de a control						
8760,	physic the t	dical	d.			_				
9 x	leath certificate attending phys i for use as the	Physician/Med	IF FEMALE: 23	c. if yes, outcome pf pregna	ancv				23d. Date	of delivery
Box	death of attended for us	ian	in the past 12_months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	al death 3	□Ectopic pregnanc □ Other (specify) _	у		Monti	· ·
Ö	the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9☐Unknown	leatii 5L					
Δ.	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
JS,	requires t een signe nould be o	by		Ů				1 □ Y	es 2 <b>∑</b> No 3	☐ Probably 4 ☐ Unknown
Ö	requ	Completed						24a. Was a	24h W	ere autopsy findings available
ě	2 2 2	npl						autop:	sv pri	or to completion of cause of ath?
트	Thate ate	S						1□ Yes	2X No 1	]Yes 2□No
/Its	yslcian: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	or:	th (Check only or	r <sup>2</sup>	
Division or Vital Records,	Physician: r this certific ral director,	은	TI Tes ZIXI 140	1 ☐ Inpatient 2 💢 28a. Date of Injury	ER/Outpatie	III OLI DON	4 🗆 Nursing n		ence 6 Other ow injury occurred	
L C	ding F n. After funera	on:	27. Manner of Death 1 Matural 5 Pending	(Month, Day Year)	Injury	Wo	rk? ]Yes 2∐No	20d. Describe II	ow injury cocurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	290 Blood of injune. At h	ome form st			28f Location (S	treet and Number	or Rural Route Number,
Ξ	or At ifter d Direc in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	fy)	reet, ractory, office		City or Tow	n, State)	or rigida rigida i tambot,
		Se	29a. Certifier 1X Certifying Physi	ician: To the best of my kno	owledge dea	th occurred at the t	ime, date and place	and due to the o	cause(s) and man	ner as stated.
	Hospital	edical	(Check only one)	er: On the basis of examina and manner stated.	ation and/or i	nvestigation, in my	opinion, death occu	urred at the time,	date and place, ar	nd due to the cause(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed	(Month, Day, Year)
			MANA BA	Male	•	D1.3	3671		Oct. 31,	2007
	30		30. Name and address of person who ep	inleted calica of death /tto:	m 23a) (Type					
			B. Manejwala, M.D.				Laurel.	MD 2070	7	
	St	ate	31. Date filed (Month, Day, Year)	32. egištrar's Sign	ature	Park a				
	Regist		NOV 0 2 200	32. egištrar's Sign	DF 19					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 State Registrar Amended#19a perFH FCHD,KS Certificate of Death 36885 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year Dav **Physician** 1:35 P. Julia **Boller** 31, 2007 /Medical October | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Frederick Frederick Birthplace (State or Foreign Country) If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 89 092-03-3306 Director 1918 January 5, Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Frederick Mt. Airy Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Paradise Avenue 21771 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 **X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Harris Hollinger Alla Belle Huff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <del>Susan Bower</del> – daughter 13801 Motter Station Road, Rocky Ridge, Maryland Susan Boller 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Graceham Cemetery Rocky Ridge, Maryland 11-3-2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Live 9 ee 1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician pheelmonio Day /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as the led by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Conce Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy performe 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:,
completely filled in by the i 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death assertion. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 /honson Thomas

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Deirdre A. Brehl 9:15 P M November 3, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 9211 Slate Quarry Road Dickerson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🕱 F 046-40-3954 61 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shor edical Examiner must be notified at Dickerson Frederick 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 20842 10g. Citizen of What Country? 9211 Slate Quarry Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, the once. Education Counselor and Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Dorothy Shea Dennis Murnane 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9211 Slate Quarry Road, Dickerson, Maryland 20842 Robert J. Brehl - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1x Burial 2 ☐ Cremation 3 ☐ Removal from State November Coshocton, Ohio 4 Donation 5 Dother (Specify) Roscoe Cemetery 9, 2007 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disea e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCIUMANC **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

Boccis 31. Date filed (Month, Day, Year)

WICHV.

29b. Signature and title of certifi

6420 and

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number

D2967

Dr. #4100

29d. Date signed (Month, Day, Year)

		se Type or Prin State of Ma 3a asper MD		Depa	delible Ink. Entry artment of Heartificate of Deartificate	Ith and,N	-	giene	ible.	20007	
Physician /Medical	Decedent's Name (First, Middle MARSHALL	e, Last) BATES	JR			t	am 2. Date of De Month OCTOBE		Year 07	3. Time of Death 9:10 A M	
Examiner	4a. Facility Name (If not institution FREDERICK MEI		4b. City, Town, or Loca FREDERICK	ation of Death		4c. County of Death FREDERICK					
Funeral Director	5. Social Security Number 579–30–1464	6. Sex 7. Ag 1 🖾 M 2 🗆 F	ge (In yrs. last b 81	oirthday) Yrs.		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, Di Sept. 1	Birth Day, Year) 10, 1926 S. Birthplace (State or For Country) Maryland			
yland now at	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation	Od. Inside City Limits					
vith the Mar or 28a-f st be notified Director	Maryland Fred	erick	Je	ffer	SON 10f. Zip Code		10g. Citizen of	What Count	1 ☐ Yes 2 No		
23a or st be r	3856 Shadywood	Drive			21755	· ·	d Sta				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Mari 3 □ Widowed 4 □ Divorced	If Yes. Give	No		Nas Decedent of Hispar f Yes, specify Cuban, M 1 ☐ Yes 2 ☑ No Sp	exican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Ra Bla Specii	an Indian, etc. .te		
ed within 72 hou yglene. ner than "natura er the Medical E it, the Medical E	15. Deceden (Specify only highe	15. Decedent's Education (Specify only highest grade completed)				g most of work	16b. Kind of E	lusiness/Ind	ustry		
d withir glene.	Elementary/Secondary (0-12)		oo NOT use retired) ne Operator			Rail:	oad				
Mental Hy Mental Hy arked othe atic event,	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surna							me)			
nd 2 sho alth and 27 is m r traum	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town,  19c. Mailing Address (Street and Number or Rural Route Number, City or Town,  14 S. Delaware Ave. Brunswick, MD 217								Code)		
Pages 1 and the properties of	20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation  4 ☐ Donation 5 ☐ Other (S		ceme	tery, crer	sition (Name of matory or other place)  n Crematory	Nov. 200	•	20c. Location	•	wn, State Iaryland	
permit. Departn Importa any infu	21. Signature of Funeral Service	Censee			Name and Address of Sthaven Fur	neral S	Service	s, Skkot	Cody	P.A.	
Physician	9501 Catoctin Mtn. Hwv. Frederick, MD 21701   23a. Part1 & er th. disease, or born lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h. fit failure. List only one cause on each line.   Probable										
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit and completed by Physician/Medical Examiner											
nat the death certificate be d by the attending physicic letached for use as the bu Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown								23d. Date of delivery Month Day Year		
w requires that the do been signed by the should be detached leted by Physia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribut  1   Yes 2   No 3							tribute to th	1/		
							24a. Was auto perf 1 Yes		prior to con death?	osy findings available npletion of cause of 2 \square No	
certific rector,	25. Was case referred to medical examiner?  Hospital:  Other:										
H B B B B B B B B B B B B B B B B B B B	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	1 ☐ Inpatie  28a. Date of Inju (Month, Da gation	ıry 28b	Outpatien  Time of Injury	IL SEL DOM 4			idence 6 □Ot how injury occu		<u>')                                    </u>	
ital or Attending R rs after death. ral Director: After led in by the funer. Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of inj	jury - At home, tc. <i>(Specify)</i>	farm, str	eet, factory, office			(Street and Num own, State)	ber or Rura	l Route Number,	
he Hospita in 24 hours he Funera pletely fille		ng Physician: To the best Examiner: On the basis o and manner st	of examination a								
To the To the Complex Management of the Comp	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo								Day, Year)		
5+1	30. Name and address of person	who completed cause of o	~ /	i) (Type,		-	Brine	10 201	<i>∞</i> 00	2/7/6	
State Registrar	31. Date filed (Month, Day, Year)	6 2007 32. Redistr	rar's Signature		Positi	Lient	1210118	w. c/c	1 1 / 2007		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Frances Hayes Beard 2007 11 3 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 129 Branch St. Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min. Months Hours 1 ☐ M 2 🕱 F 160-24-5824 77 2/18/1930 PA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits TX Yes 2 No MD Worcester Berlin 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 129 Branch St. 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Caregiver <u> Health Care</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Bryant Hayes Rebecca Lindsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Beard Mansell / daughter 18 N. Lansdowne Ave., Lansdowne, PA 19050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Cape Henlopen Crem. 11/5/07 Frankford, DE 22. Name and Address of Facility 21. Signature of Fune al Service Licensee The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VA MINIGIES resulting in death) Due to (or as a consequence of): SEVERAL YRS HYPERTEN SIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2011 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

show

"natural", or items 23a or 28a-f shov edical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examines and.

Baltimore, Maryland 21215-0036

death v

Director

Funeral

δ

Completed

Be

Examine physician and s the burial-transit use as signed by the attending be detached for use a: ate has b funeral director, After To the river after death, within 24 hours after death, To the Funeral Director: Aft

The law requires that the death certificate be executed

or Attending Physician:

the Hospitai

Division or Vital Records, P.O. Box 68760,

Physician/Medical 2 Be Completed Certification: To

Medical

27. Manner of Death 1 Natural 2 ☐ Accident

> 3 ☐ Suicide 4 Homicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

28d. Describe how injury occurred

203 SNOW ST. SNOW HILL MD. 21863

 Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 25 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZWORTH

29d. Date signed (Month, Day, Year)

BA 6 State Registrar

2007 NOV 0 5

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 007 36889 For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 6. **Physician** 10:00A M BOOTH VIRGINIA LEE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
WILLIAMSPORT NURSING HOME 4b. City, Town, or Location of Death Examiner WASHINGTON WILLIAMSPORT | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y 11/18/1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** 1 ☐ M 2 ☐ **/**F 82 WEST VIRGINIA Yrs. 232-32-8932 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State il Hygiene. . other than "natural", or Iteme 23a or 28a-1 ehow vant, the Madical Examinar must be notified at YNYes 2 No WILLIAMSPORT Director WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 137 N. ARTISAN STREET 21795 Completed by Funeral filed within 72 hours after death 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify. Specify: WHITE 3 ☑ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CHURCH Elementary/Secondary (0-12) College (1-4or 5+) ORGANIST permit. Peges 1 and 2 should be file. Department of Heelth and Mentel Hyg Important: If Item 271s marked other eny Injury or other traumericant. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LENA HALL HAYWARD SUMMERVILLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 237 S. ROSEMONT AVENUE, MARTINSBURG, WV 25401 DEBORAH BOOTH MYERS/DAUGHTER 20a. Method of Disposition
1 Dispurial 2 Cremation 3 Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) BRICK CHURCH CEMETERY LOST CREEK, WV 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME, P.O. BOX 821, 21. Signature of Funeral Service Licenses 327 W. KING ST., MARTINSBURG, WV 25402 les laur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PUELMONIA WEEK VIZAL **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown SENTLE DEMENTIA ADVANCED Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No certificate : After this certifice funeral director, t 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 🔀 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No I Diractor: A investigation death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dirac 1.2 Certifying Physiciam. To the best of my knowledge, death onsuited at the time, date and due to the dause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Curtiflor Medical (Check only one) and manner stated. ţ, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NOVEMBER 6, 2007 N 33700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21795 WILLIAMS PORT, HRTIZAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 36890 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 10-30-2007 6:58  $P^{M}$ MARIA CIURAR /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country)
Recas, Romania If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12–17–1933 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min 1 □ M 2 🛣 F Yrs 73 352-82-8686 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. of Health and Mental Hygiene are 1 shown in 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantance. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1-EYes 2 □ No Director Buford Georgia Gwinnett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Romania 30519 3256 Sable Ridge Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: Romanian Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ana Cirpaci Anton Mahai ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 nent of Health a ant: If item 27 is ury or other trau Buford, Georgia 30519 3256 Sable Ridge Dr. Ion Ciurar/husband Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 3, 2007 1 ☑ Burial 2 □ Cremation 3 ☑ Removal from State 4 □ Donation 5 □ Other (Specify) Department o Important: If any Injury or E. Shadowland Memorial Lawrenceville, GA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mary Hedgman M01374 Cedar Hill FH 4111 PA Ave. Suitland, MD 20746 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Malignant Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-P.O. Box 68760, Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Respiratory Failure Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an performed? Yes 2 No page certificate ! 1∐ Yes **Division or Vital** Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Director: After (Month, Day Year) or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11-01-2007 D0037066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6188 Oxon Hill Rd #701 Oxon Hill, Maryland 20745 Uchechi Opaigbeogu,MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)
NOV 0 2 2007 State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	laryland .	/ Depa	artment rtificate	of H	ealth a	and M		giene Reg. No.		30031
- 27	An a		Decedent's Name (First, Middle, La	st)							2. Date of De	ath		3. Time of Death
	Physici		Olive Justine Cook								Month Octob	er 2	6, 2007	10:00 A M
1	/Medic Examin		4a. Facility Name (If not institution, give		r)		4b. City, T	Town, or	Location of	of Death	0000	-	County of Deat	
Assess	Examin	er	Montgomery Gener				Olne	ρV				M	ontgome	rv
100	Funeral		5. Social Security Number 6. S	Sex 7. A	lge (In yrs. last	birthday)	If Under	1 Year	If Under		8. Date of Bir (Month, Da	rth		hplace (State or Foreign
el.	Director	-	214-60-2530	1□M 2ĂF	87	Yrs.	Months	Days	Hours	Min.	Nov. 1	2, 1	919 Ne	braska
	D		Usual Residence of Decedent											
	rylan		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits 1 XYes 2 No
	e Ma	cto	Maryland Montgome	ry	Rockv	ville								
	th th	Directo	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of What Co	ountry?
	23a	ai	4117 Great Oak	Road				853					S.A.	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23a or 28e-f show ther than "natural", or flems 23a or 28e-f show ent, the Medical Exertinat relations.	Funerai	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Decede If Yes, spec	ent of Hi ify Cuba	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	0-	<ol> <li>Race - Ame Black, Whit</li> </ol>	
36	or li	y F.	1 Never Married 2 Married	1 ☐ Yes 2X If Yes, Give			1 ☐ Yes 2	No	Specify:				Specify:	TT- 4 + -
Maryland 21215-0036	ural'	d by	3 Widowed 4 Divorced	Year or Dates		ICO Door	dontin I lava	1.000.00	atio a			16h K	ind of Business	White
īγ	"nat	Completed	15. Decedent's E (Specify only highest gr		'	(Give	dent's Usua kind of wor DO NOT us	k done a	luring mos	t of work	ing	100.10	110 01 003111033	maasty
12	withii ene. than	g m	Elementary/Secondary (0-12)	College (1-40	r 5+)		Teach					E	ducatio	n
א ס	filled Hygi ther int, th		17. Father's Name (First, Middle, Last	<u>.</u>			Teach		18. Moth	er's Name	e (First, Middle	_		
an	d be antal	o Be	Lowell Sanford	Nevins					T or	na N	Mitchel	1		
2	shoul nd Me mark matti	2	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a					or Town, State,	Zip Code)
<u>S</u>	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Dept. riment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28e-f show any njury or other treumatic event, the Medical Experiment and burnchilled at once.		Nerissa J. Cook	•	er	4117	Great	t Oa	k Ros	ad Ro	ckvill	e M	aryland	20853
ē,	Hea Hea tem	1.8	20a. Method of Disposition	/ Daugitt			osition (Nam matory or of				Date		ocation - City or	
<u>o</u> L	ages ant of it: if i		1 🖾 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		10				1	NT OFF	10 07	A == 1	ington.	Vo
Baltimore,	rtan njur		21. Signature of Fugeral Service Lice		ALLI								's Sons	
ä	Per Per Per Per Per Per Per Per Per Per		Valille in 1	Bus	41-						A RESIDENCE   11			D.C. 20016
	:	770	23a. Part1. Enter the disea at or son	nplications that cans	the death.		and the same of th						Inguo.	Approximate
, ,		i i	23a. Part 1. Enter the disease, or simplications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eich line.  Immediate Cause (Final								Interval Between Onset and Death			
	Physician /Medical	g r	disease or condition resulting in death)	a. Ven	as a consequer	Cert	o u	M	eca	ren				1. Marin
1.	Examiner				as a consequen	A	of is	1	In	las	- the	n		1 most
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequer	nce of):	-0	7 -			<u>~~~</u>			
>	uted d ansit	min												
Ć,	exec n en ial-tra	Examiner	resulting in death) Last	Due to (or a	as a consequer	nce of):								
8760,	cate be executed obysicien end the burial-transit			d										
9	g phy as th	edi	-											
Вох	The law requires that the death certificate be executed at hes been signed by the attending physicien end page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy		⊒Ectopic pr	eanancy					23d. Date of de	,
	deat e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant	at time of deat		Other (sp						Month	Day Year
<u>Р</u> .	t the by th	hys	9 ☐ Unknown	9 Unknown										
	an tha	by P	Part II. Other significant conditions	contributing to death	but not resulting	ng in the u	inderlying c	ase givi	en in Part	Ι.	23e. Did	tobacco		o the cause of death?
ğ	aquire en sig	ed	Compl	eto H	ear	J.	200				1 🗆	Yes 2	Mo 3∏P	robably 4 Unknown
CC	awre as be	piet									24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
Division of Vital Records,	The lav	Completed									peri	formed? 2 ☑ No	death?	
ţa	Physicien: Th r this certificate ral director, pag	Bec	25. Was case referred to medical						26. Plac	e of Deat	h (Check only	one)		
<b>&gt;</b>	Physic this ce al direc	ToE	examiner? 1 Yes 2 No	Hospital: 1 🗆 Inpa	atient 2 F	VOutpatie	nt 3 DC	Oth	er: 4□N	ursing Ho	me 5 Res	sidence	6 □Other (Spe	ecify)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury 28 Day Year)	Bb. Time o	of 2	8c. Injun Wor	y at k?		28d. Describe	how inju	iry occurred	
<u>Ö</u>	Attending in death.	atic	2 Accident investigation				М	1 🗆	Yes 2□	]No				
ž	or Atte	Certification:	3 Surcide 6 Could not determined	288. Place 01	Injury - At home etc. (Specify)	e, farm, st	reet, factory	, office				(Street as		lural Route Number,
	Itel or rs afte rei Dir led in	Cer												
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	hysician: To the be minar: On the basis	of examination									
	the I	Med	one)	and manner	stated.		20-	Linenc	a numba-			אם אפע	ate signed (Mon	th Day Year)
	To To To	-	29b. Signature and title of certifier	7	A	1.0	290	. Licens	e number	0		23U. DE	_/	O 200 1
	10		1/steris	10	My V	71)	4	4	>0		1	0	T 40	700%
	( -		30. Name and address of person who	completed cause of	0 12	За) (Туре	Print)	1-	λ '	A.	Cit	12 -	- 100	non Ma
			Kopert Co	14 13/	Strar's Signatur	ince	1hr	rige	DN	we	mull	14)		1,10
	Sta Regist		31. Date filed (Month, Day, Year)	2007 32. egi	strai s signatur	1	needs 1	9						V
D	MU 17 Day 15	004		1000		19								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Dav Year **Physician** 4:50 PM 29, KUI PUILING CHUCK OCT. 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Hebrew Home of Greater Wash. Rockville 8. Date of Birth (Month, Day, Year) Mar. 3, 1928 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** China Days Months Hours 1 M 200 217-15-7856 79 Yrs Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "neturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 FYes 2 No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 95 Dawson Avenue, #401 20850 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Asian Specify: þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th Housekeeping <u> Holiday Inn</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be innent of Heelth and Mental I ant: If Item 27 Is marked o Kan Lum Kui Tsui Po Luk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth as Important: If Item 27 le eny Injury or other tree once. Jean Cheng (Granddaughter) 4857 Battery Ln, #405, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 12 Burjar 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) Parklawn Mem Park 11/6/07 Rockville, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 Donot enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that will tend as your line). Examiner Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: or Attending 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel Tecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier D0036716 October 28 2007 ated cause of death (Item 23a) (Type, Print) G121 Montresald, Nockville, Md 20852 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 27, 2007 Physician 9:00 P Beatrice Gelbgras Chester /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/01/1925 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 K F 087-18-6471 82 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ns 23a or 28a-f show must be notified at 1 XYes 2 No MD N. Bethesda Montgomery Director 10f. Zip Code 20852 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with Hygiene. United States 11200 Empire Lane Funeral ural", or items 2 I Exaπiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natur 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Labor Law 5+ Attorney 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be ealth and Mental Frances Offenberg Paul Gelbgras ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 65 Valerian Court N. Bethesda MD 20852 Health a Charles Chester - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 ament of He 20a. Method of Disposition Department of I Important: If its any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/30/07 Olney, MD Judean Memorial Gardens 4 Donation 5 Other (Specify) Danzansky-Goldberg Memorial Chapels Inc. 1170 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed STAGE and I-tran Due to (or as a consequence of) physician are the burial-t Physician/Medical attending ph Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? page 2) No Vital certificate 1∐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) L<sub>o</sub> 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA CHESTER, 10127/07 Division or 1.X Inpatient within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062999 October 23 2007 10 30. Name and address of person w Petek Donmez MD cause of death (Item 23a) (Type, Print)
Rockville Pike Rockville MD 20852 who completed 11119 31. Date filed (Month, Day, gistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

TRIC

EA.

100

2007

			•	pe or Print in					•					
			For State	State of Maryla	•			Mer		0000	00001			
			Registrar		Cei	rtificate of	Death	1 -		g. No2 U U /	36894			
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Arlington Wood:				Date of Death Month	Day Year	3. Time of Death 12:20A M					
	Examin		4a. Facility Name (If not institution, give street 8920 01d Hagers		or Location of Dea ${ m ld}{ m let}{ m owr}$			4c. County of Dear						
	Funeral Director		5. Social Security Number 6. Sex 1 214 - 34 - 0462	If Under 1 Year Months Days		9. Biri 8, 1937	thplace (State or Foreign nuntry) MD							
			Usual Residence of Decedent  10a. State 10b. County	70 10c. C	ity, Town or Lo	cation			ar. 2		10d. Inside City Limits			
	y within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Director	MD Freder	ick	Mi	ddletow	'n				1 □Yes 2 No			
	h with the	al Dire	10e. Street and Number 8920 Old Hagers	town Rd.		10f. Zip Code 217	69		10	g. Citizen of What Co US				
	deat	Funeral	11. Marital Status	. Was Decedent Ever in Armed Forces? 1 (	U.S. 13.	Was Decedent of	Hispanic Origin? (	Specify	Yes or No-	14. Race - Ame Black, Whit				
5-0036	urs after al", or ite 'xamine	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	, , ,	1 □ Yes 2 □ <b>x</b> No		Specify: W							
ž	2 hou	ted	15. Decedent's Educa (Specify only highest grade of	tion	16a. Dece	dent's Usual Occu	pation during most of we	rkina	1	6b. Kind of Business	'Industry			
7	tthin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)	JIKIIIY		defense	h o 10			
7	filed within Hygiene. Ither than "	To Be Con	1.2		rece	iving m		(5		contrac	tor			
land	m = 0 &		17. Father's Name (First, Middle, Last)  Augtin I. Cramer  Morry Mil							ler				
Maryland	s 1 and 2 should be f Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type Mary Helen Crame							City or Town, State, .	Zip Code) 21769 Own, MD			
ē,			20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other pla	ace)	Date	2	0c. Location - City or	Town, State			
Ē	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)				ery 11/	5/	2007 1	Middleto	wn, MD			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	LOATE	22	bonald P. O. B	B. Thom	pso Mi	on Fun	neral Horown, MD	me 21.769			
	1.5		23a. Part1. Enter the disease, or complica shock or heart failure. List only one	ations that caused the decause on each line.	ath. Do not ent	er the mode of dy	ing, such as cardia	ac or re	spiratory arre		Approximate Interval Between			
·	Physician		Immediate Occurs (Einst	metastation	c neur	o end oc	vine turn	101			Onset and Death			
	/Medical Examiner		Due to (or as a consequence of):											
V <sub>2</sub>	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):										
o O	eath certificate be executed attending physician and for use as the burial-transit	Examiner	resulting in death) Last  Due to (or as a consequence of):											
09/89	cate be physicia the bu	dical	<b>d</b>											
ROX	death certificate e attending physi d for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome pf preg						23d. Date of de	livery			
ğ Ö	00	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	months?   1 DEIVE birth 2 Detail death 3 Decropic pregnancy   Month   No   4 Department at time of death 5 Other (specify)   Month   M							Day Year			
<u>ര്</u> ച	law requires that the deas been signed by the 2 should be detached	by Ph	That is, other significant continuous continuous to death but not resulting in the underlying cause given in That is.								o the cause of death?			
Hecords,	w requi	leted							24a. Was an		utopsy findings available			
	The ate has bage	Completed							autopsy pertorm 1□ Yes 2	prior to	completion of cause of			
VItal	iclan sertific sector,	Be	25. Was case referred to medical examiner?	enital:			26. Place of De	eath (C	heck only one	)				
0	Physical direction	: To	1 ☐ Yes 2 No CON 27. Manner of Death	spital: 1 ☐ Inpatient 2 [ 28a. Date of Injury	28b. Time o	IL 3 DOA				nce 6 Other (Spe w injury occurred	ocify)			
ion	ending ath. or: Afte he fune	ation	1 Natural 5 □ Pending investigation	(Month, Day Year)	Injury		ork? ]Yes 2 □No							
DIVISION	al or Atter de after de l'Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined building, etc. (Specify)  5 ☐ Could not be determined building, etc. (Specify)  5 ☐ Could not be determined building, etc. (Specify)  5 ☐ Could not be determined building, etc. (Specify)							ural Route Number,				
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, is	Medical C		cian: To the best of my kier: On the basis of examinand manner stated.										
	To the within To the comple	Me	29b. Signature and title of certifigr	Man M	$\bigcap$	29c. Licer	ise number	11,	29	d. Date signed (Mon	th, Day, Year)			
1	2		30. Name and address of person who com	pleted cause of death (Ite	em 23a) (Type.	Print	4012	7		11/2/01	1			
1	-		Elhamy Eskande 31. Date filed Month, Day, Year)	MD 50	1 1 -	77h Stree	et tr	de	sick,	MD 2	170			
	Sta Registr			2007 > Alexander	J	Coste	•							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2007 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 12, 2007 1258 **Physician** Greta May Cullum /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sunbridge of Elkton Cecil Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 12/14/1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min Months Maryland 1 ☐ M 2 🛣 F 90 Yrs. 218-32-9886 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b County 10a State ingright the politied at 1 Yes 2 No Harford Aberdeen MD Direct 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number U.S.A. 21001 490 Roberts Way Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. I □ Yes 2**X** No If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☐ No Specify Completed by 3 Widowed 4 □ Divorced Year or Dates "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry and Mental Hygiene.

Is marked other than "natur sumstic avant, the Medical Elementary/Secondary (0-12) College (1-4or 5+) In home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Georgianna Harrington Charles Walter Armour 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any injury or other trat once. Aberdeen, Maryland 21001 490 Roberts Way Irene M. Hill (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Bel Air Mem. Gdns. 11/16/07 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alherosclerotic Heart Disease years **Physician** disease or condition resulting in death) /Medical Digheter Mellity Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a Examiner Hypertension or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to dr as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After thi funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 28l. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 10023322 Sachder 5 MD 118 North St Swite 3B, Elston MD 21921. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. SACHDEUMD 32. Registrar's Signature 31. Date liled (Month, Day, Year) State NOV 1 7 2007 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

36896 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12 Dignan 07 Kathy 11 1055 /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS Braddock Campus Cumberland Allegany 8. Date of Birth (Month, Day, Year)

Jan 29, 1955 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 □ F Director 52 ΜD 215-74-5689 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked as 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland 1 ☐ Yes 2 ☐ No MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 309 Wills Creek Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Eugene M. Light Ruth L. (Bartlett) Light 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Wills Creek Avenue Cumberland MD 21502 Gregory Dignan husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 11/17/2001 Cumberland MD 4 ☐ Donation \_\_5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Parla. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMONARY EMBOLISMS - BILATERAL Same day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as the burial-tran-Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fet al dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 힏 in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) detached the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 DUnknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 1☑ Yes 2☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 3□ DOA 2□ No 1 Inpatient 2 ER/Outpatient Certification: To filled in by the funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/14/07 Conarelyn en K Nelseen 20065518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mi State Community Health 621 Kelly Rd Cumberland Maryland 21502 Marilyn Pelson 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

		•	1 - State Registrar Amend #2, 2	State of M 20b, 11-7	Marylar -07,	nd/Depa per E	irtmei Viirca	nt of H	lealth and Death	d Me	ntal Hy	giene Reg. No.	200	7	36	89
Phy	/sicia		1. Decedent's Name (First, Middle, Las	st)						2	Date of Dea Month	ath Day	20Q	7 ear	3. Time o	of Death
	ledica	al -	Evelyn Sh			er					Novemb		10		8:50	$A^{N}$
Exa	amine	er	4a. Facility Name (If not institution, give 8518 Horseshoe Ro		er)				Location of De				County of	_		
			5. Social Security Number 6. S		Age //g yrs	. last birthday)		r 1 Year	tt City		Date of Birt		Howa		ace (State	or Foreig
Fune Direc				_ M 2 ☐ ¥	69	Yrs.	Months			lin.	Date of Birt (Month, Da)	y, Year) , 19	_	Count	essec	
Р.			Usual Residence of Decedent									1	-			
anylar	1	_	10a. State 10b. County			ity, Town or Lo								10	d. Inside C	City Limit: s 2 <b>∃</b> xNo
he M.	otitie	ecto	MD Howard		E	llicott										2 4
with t	1	5	10e. Street and Number 8518 Horseshoe Ro	her.				p Code 21043					en of Wha		•	
leath	E I	Funeral Director	11. Marital Status	12. Was Decede	nt Ever in U	J.S. 13. V			ispanic Origin?	(Specif	v Yes or No-		ited 4. Race -			
ING 21215-0036  be filed within 72 hours atter death with the Maryland hall Hygiene.  do ther than "natural", or items 23a or 28a-f show	Distriction		1 Never Married 2 Married	Armed Force 1 ☐ Yes 2		'	f Yes, spe	cify Cuba	ın, Mexican, Pu	ierto Ric	an, etc.)		Black,	White, e	etc.	
ours a	Exa	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Date:	s:		I □ Yes	2 X No	Specify:				Specify:	Wh	ite	
72 h	CICO	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	kind of w	ork done	during most of	working		16b. Kin	d of Busin	ness/Ind	lustry	
21215-0036 ad within 72 hours at giene.	e We	d E	Elementary/Secondary (0-12)	College (1-4c	or 5+)			Dane I								
filed v Hygie	5		17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·		SCI	100T	Bus I	Driver 18. Mother's N	Vame (F	First Middle			<u> Fia</u>	ucati	on
Maryland Id 2 should be file th and Mental Hy 77 is marked other	> ·	m	Eber Massengill						Ruth				,			
Tarylar 2 should be and Menta is marked	Tem!	၀	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	g Addres	s (Street a	and Number or		•	r, City or	Town, Sta	ate, Zip	Code)	
C = ''	other traumatic		Sharon Delawder/D	aughter		8518	Hors	esho	e Road	E114	iontt (	Ci+vz	MT	210	43	
Baltimore, permit. Pages 1 an Department of Heal mportant: If itam 2	othe		20a. Method of Disposition			Place of Dispo	sition (Na	me of		Date	9	20c. Loc	ation - Ci	y or To	wn, State	
Pages nent of nnt: If it	iry or		1 Bunal 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify		te	eadowri				-5-0	7	Elkr:	idge,	MD		
Baltimor  permit. Pages Department of h Important: If its	any inju		21. Signature of Funeral Service Licer	see ///	M01	044 22	. Name a	nd Addres	s of Facility H	arry					ly FH	Inc
n aces	2 9		Dem alla	- With	1				olumbia							
S/60, safe be executed bubysician and physician and the initial traces.	ner neusit	Exam	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Du	as a consec			m u	en of a	urne	un II	imit			8 mo	wh
death certific	ached for use as	nysician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of c	al death 3 death 5	Ectopic p	pecity)					3d. Date of Month		Ďay	Year
dS, tuires that uires that is signed	e .	2	Part II. Other significant conditions c	ontributing to death	but not res	sulting in the ur	ndertying	cause give	en in Part I.		23e. Did to				ecause of	
VITAL RECORDS, P.O. sician: The law requires that the certificate has been signed by the record mans 2 should be described.	age z snou	Completed								_			pridea	r to com	sy findings	available cause of
	ior, p	a)	25. Was case reterred to medical						26. Place of D	Death (C				103	2,40	
- × ×		0 0	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpa	itient 2	ER/Outpatien	3 D	Othe	er: 4 🗍 Nursing	g Home	5 XResid	lence 6	Other	(Specify,	)	
JON O Jing Pt After th	neral.		27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Ir (Month, L	njury Day Year)	28b. Time of Injury		28c. Injury Work	at c?	280	1. Describe h	ow injury	occurred			
or Attendifier death	n en ya ni e	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At h etc. (Speci	nome, farm, stre	M .		Yes 2 □ No	28f	Location (S City or Tow		Number	or Rural	Route Nun	n <i>ber</i> ,
To the Hospital within 24 hours a To the Funeral I	Stetery rille	edical C	29a. Certifier 1 ★Certifying Ph (Check only one)	ysician: To the be niner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred	at the tim	ne, date and pla pinion, death or	ace, and	due to the dat the time, d	cause(s) a date and	and mann place, and	er as sta I due to	ated. the cause(	s)
To the P within 24 To the P	Com		29b. Signature and title of certifier	111				c. License					signed (/			
			1 lichelus Ku	wickt	NES		1	385	09		11	Oven	chec	2:	2007	
600			30. Name and address of person who have the LHS Kowfreke	completed cause o	death (Iter	m 23a) (Type, I	Print)	4 Pa	ivg utwas Co	oluu	uh:in	ma	ry 141	un a	2104	4
Rec	State	-	31. Date filed (Month, Day, Year)		strar's Signa	ature	mast.	B	) 01	18-0						

24 hours af e Funeral D letely filled in Medical To the Hosp within 24 hou To the Fune completely fi

State Registrar

29a. Certifier

29b. Signature and title of certifier Riekers rendy

(000 SO21

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

10/23/2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wendy Riekers, M.D.

medical Anne Arande 1

31. Date filed (Month, Day, Year) OCT 2 5 2007 32. Pegistrar's Signature

DHMH 17 Rev 1/2001

			For State	State of Ma	-	partment of contracts		ind Mental		2011	36900
			Registrar  1. Decedent's Name (First, Middle, La	est)		- Crimouto	or Boatin	2. Date	Reg. Nof Death	NO.	3. Time of Death
	Physici		Cladias	Jessie		1	1 1	Mont		Day Year	7 6750 M
}	/Medio		4a. Facility Name (If not institution, give			4h City To	wn, or Location of	Death		4c. County of Dea	1
	Examin	er	D. 1 1.	Hookhs	Mosnital	12.1	1			Baltimo	
	Francis				(In yrs. last birth	(av) If Under 1	far   If Under 2	24 Hrs. 8. Date	of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		-	1 □ M 2½0 F	82 Yr	Months F	ays Hours	Min. (Mon. Jan.	th, Day, Yea	ar) C	w Jerseu
			Usual Residence of Decedent					ban.	25,	1727 NE	w beiseg
	ylany now		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Mar.	ţċ	Maryland Washin	gton		На	agerstow	n			1 No 2 No
	7.28.	Director	10e. Street and Number			10f. Zip Co			10g. (	Citizen of What Co	ountry?
	h wit		70 East Irvin	Ave.			21742			U.S.A.	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Madical Examinar must be notified at	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deceden	t of Hispanic Orig	jin? (Specify Yes Puerto Rican, et	or No-	14. Race - Ame	
9	after or ite	2	1 ☐ Never Married 2 ☑ Married	1 Yes 2 XN	0			, Fuelto Alcan, et	G.)	Black, Whi	te, etc.
5-003	raf',	t by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 ☑	тио зресну.			Specify: W.	hite
2	72 h natu	Completed	15. Decedent's E (Specify only highest gr			ecedent's Usual C	occupation fone during most	of working	16b.	Kind of Business	/Industry
2121	thu and the	npi	Elementary/Secondary (0-12)	College (1-4or 5-		e. DO NDT use	retired)	g			
7	tiled wi Hygien sther th	S	12			Ope:	rator			Telepho	ne
p	a Hyani	Be	17. Father's Name (First, Middle, Last	")			18. Mother	's Name (First, M	liddle, Maide	en Sumame)	
<u> </u>	should be ind Mental I marked o	ပို	Thomas Cross.	ley				Emma Gar	lock		
Maryland	and and sm sum	1	19a. Informant's Name/Relationship	(Type, Print)		,				y or Town, State,	
	₽ <b>5</b> 2 <b>2</b> 5		Albert Donus	(Husband)					own, I	Maryland	21742
ore.	m O L		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Domoval from State	20b. Place of D cemetery,	sposition (Name crematory or othe		Date November	20c.	Location - City or	Town, State
altimore,	Pages nent of ant: If it ary or o		'4 □Donation 5 □ Other (Speci		Smithsh	urg Cren		15, 2007	Smi	ithsburg	, Maryland
a	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	nsee		22. Name and	Address of Facility	J.L.	Davis	s Funera.	l Home
m	89 2 2 8	2.7	Jake for	Davis Me	1414	12525 Bi	adbury 2	Ave. Smi	thsbui	rg, Mary.	land 21783
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not	enter the mode o	f dying, such as c	cardiac or respirat	ory arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	Acule	Ruch	Time	1 1-	1. 1.	<i>a</i> .		Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	conse uence of)	- 17 ha	7	vtc An	rury	JM	1 day
	Examiner										
		Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consuquence of						
D	cute od ransi	Examin	that initiated events	c							
ò	te be executêd ysician and e burial-transit	E	resulting in death) Last	Due to (or as a	consequence of)						
8760,	cate be executed physician and the burial-transii	dicai		_ d						<u> </u>	
9		Med	IF FEMALE:								
ROX	death certifi e attending i d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2		3 ☐ Ectopic pregi	апсу		ĺ	23d. Date of de Month	livery Day Year
	0 0 0	sici	1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	ime of death	5 Other (speci	fy)		_	WORTH	Day real
J.	The law requires that the te has been signed by the sage 2 should be detached.	Phy	9 Unknown					1	5		
ś	signed b	by	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying caus	sa given in Part I.	238.			the cause of death?
ord	w requir been si should	ted				-		_   _	1 🗆 Yes	2   No 3   P	robably 4 Unknown
Vital Records,	law i	Completed						24a.	Was an autopsy	prior to	utopsy findings available completion of cause of
r		Son						10	performed? Yes 2.50 N	death?	200 No
<u>=</u>	ician: Th certiticate ector, pag	Be (	25. Was case referred to medical examiner?					of Death (Check	only one)		
<u>5</u>	hysic nis ce I dire	၉	1 □ Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outpa	tient 3 DOA	Other: 4 Nur	sing Home 5	Residence	6 ☐Other (Spe	cify)
C	ding Ph h. After th funeral	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Ye <i>ar)</i> 28b. Tim	e of 28c.	Injury at Work?	28d. Desc	cribe how in	jury occurred	
000	tandi leath. tor: A the fu	ati	2 Accident investigation			М	1 ☐ Yes 2 ☐ N	lo			
DIVISION	ter de iract	Certification:	3 Suicide 6 Could not be determined		y - At home, farm (Specify)	street, factory, o	ffice	28f. Local City	tion (Street a or Town, Sta	and Number or R ate)	ural Route Number,
	ital curs at ral D										
	To the Hospital or Attanding Physician: while 24 hours after death. To the Funeral Birector: After this certifica completely tilled in by the funeral director,	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of o	examination and/o	eath occurred at t r investigation, in	he time, date and my opinion, death	place, and due to hoccurred at the	o the cause time, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	tha hin 2 tha mplet	Med	one)	and manner stat	ed.	200 1	icense number		204 5	Pata signed /Mass	th Day Your
	5 iž 5		29b. Signature and title of certifier							Date signed (Mont	
			'	- Vi	(1)	K	45-01	00	1100	vember	15 2007
	A		30. Name and address of person who	1. //	ath (Item 23a) (Ty	pe, Print)	10 0	/	2 1 1	1	13 2007 Nayland 21287
			31. Date filed (Month, Day, Year)	-lm y 6 C	's Signature	- 1h W	olfe St	reet 1	salti	nore 1	ilong land 21287
	Sta Registr	_		107 Abdustral	's Signature	2346					
	3.00		FROM B we B green	The state of the s	9 6						

State of Maryland / Department of Health and Mental Hygiene 17 36901 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Warren Reynolds Ewing November 10 0035 A 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Abbey Manor Assisted Living E1kton Ceci1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) NOV 7, 192 **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**∑**M 2□F Yrs. Director 216-18-7966 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits and Mental Hygiene. Is marked other then "netural", or iteme 23a or 28a-f ehow reumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 Fairview Road 21921 United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: 3 

Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Clerk Aerospace 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leon VanSant Ewing Mabel H. Hilaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Ewing Cohn/Daughter 8 Tower Point Rd., Chesapeake City, MD 21915 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Friends Burial Ground 14, 2007 Calvert, Maryland Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Obstructive Lung Disease Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Due to (or as a consequence of): Examiner Lung y cars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of). P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death ned by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be Completed by 3 Probably 4 dunknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Yes 2 No Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certified aduder SMI) 100023322 11.12.2007 140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 3B, Elkum MD21921 SACHDEV MD, 118 Nortz Stant, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 9 2007 Registrar

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11, 2007 10:21 AM Nov. LUCILLE ENSOR WANDA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Norrisville Sunshine Acres If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 📉 F 216-28-8363 Director 78 Yrs. Maryland Usual Residence of Decedent e filed within 72 hours effer deeth with the Maryland al Hygiene.
other than "natural", or Itama 23a or 28a-1 ahow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Director White Hall MD. Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21161 3112 Troyer Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembly Tools permit. Peges 1 and 2 should be filed w Department of Heelth and Mental Hygiel Important: if Itam 27 te marked other it any Injury or other traumatic avant, ILS ODCS. Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Nelson William Leslie Troyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Troyer Rd. White Hall, MD. 21161 John E. Ensor (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Carroll Cremation 11/13/07 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.

Immediate Cause (Final disease or condition Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onser and Death **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 210-No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Moepital or Attanding I within 24 hours efter deeth. To the Funeral Director: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number | 3452 | 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie who completed cause ondeath (Item 23a) (Type Print) VACEL 21030 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 7 2007 Registrar

DHMH 17 Rev 1/2001

# Li 20, beth E , E vans Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygien Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year 810 AM Elizabeth Ellen Evans 2007 /Medical November 13 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fahrney - Keedy Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month Day, Year May 30, 1 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 277 F Director 219-14-9585 92 Yrs. Maryland Usual Residence of Decedent 10a. State 10b. County 28e-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at 1 Yes 2 No Maryland Washington Boonsboro Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 8126 Mapleville Road 21713 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò þ 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 X Divorced White Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker other Home othar traumetic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Joseph F. Hose Carrie Shifler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
eny injury or other trau Jo Ann Smith (Daughter) 8126 Mapleville Rd. Boonsboro, Maryland 21713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

`4 ☐ Donation 5 ☐ Other (Specify) November Smithsburg Crematory 16, 2007 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Jell MO14/4 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 19VIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SCHEMUC disease or condition resulting in death) 0 /Medical Due to (or as a consequence of): Examiner lu dua Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the use as t IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Yes 25 No detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Valursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No b 2 this After this funeral of 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Attending 1 Spatural A hours after de...

\*\*rell Director: An...

\*\*in by the fur-5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🖺 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or within 24 hours a

To the Funaral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2323 30. Name and address of person who completed cause o ath (Item 23a) (Type, Print) Dr. Khalid M. Waseem 1126 Opal Crt. Hagerstown, MD 21742 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

NOV 1 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#8perFH, G899, 1/4/2010, WS State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amended#19a perFH/FCHD/d1c Certificate of Death 11/6/07 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 2007 OCTOBER 31, 11:07A ROBERT EVAN FRANKLIN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth Azy 18,1947 Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex. 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** 214-48-3872 60 MO. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturai", or items 23a or 28a-f shov edicai Examiner must be notified at MO. FREDERICK FREDERICK 1 ✓Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Fieldpoint 3*5*0 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☑ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Year or Dates: Completed Medicai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION CEMENT 10 FINISHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MANKLIN Scott JANIE 2 SEN JAMIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health ar important: if item 27 is any Injury or other tra son 103 Frederick Md, 21701 Field 350 c 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Frederick M4 Sunny side Unc 1017,2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CARY L. 21. Signature of Funeral Service Licensee ROUMS FIN-HOME Kuyor 01 KEDERICK MO 21701 IN WIST SOUTH 57 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo candial Physician aute /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 24 No 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA 1 Yes 2 No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD. MOD 0054636 NOV. 3, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 700 Montalin Ave Redeal Mil 21701 Syca Haque

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 0 6

2007

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Reg. No.2 0 0 7 36906 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2007 12:45P Farl Richard Grinder November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**X** M 2 □ F Yrs. Sept. 22, 1931 76 220-28-3594 Maryland Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at XYes 2 □ No Directo Maryland Carroll Union Bridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ural", or items 23a or Examiner must be r 309 Thomas St. 21791 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White natural", Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 machinist cement company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ပ Maurice Lee Grinder Lula Mae Hooper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Union Bridge, MD 21791 Betty J. Grinder/ wife 309 Thomas St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 11/15/2007 | Union Bridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cem. 21. Signification of the second of the secon 22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ADENOCARCINOMA ESOPHAGUE **Physician** MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, C. and Due to (or as a consequence of): physician s the burial Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the f

> State Registrar

Medical

B

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifie

M

501

and manner stated.

32. Registrar's Signature

30. Name an inddress of person who completed cause of death (Item 23a) (Type, Print)

O'GONNOR

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

A31761

W. SEVENTA ST.

29d. Date signed (Month, Day, Year)

			Registrar	#19a Per	INF G	373 <b>1</b> 1,	/19/07 S		-	ate of	Death		Reg		007	36	
	Physicia	an	1. Decedent's Nam			TC.						Mont		Day 20, 2	Year	3. Time o	
	/Medic		MILDRED  4a. Facility Name (				per)		4b. C	City, Town, o	r Location of Deat		DEK 2		nty of Death	9:43	A
	Examin	eı	HEBREW H		-			TON		ROCK	VILLE			MO	NTGOME	ERY	
i	Funeral		5. Social Security N	Number	6. Sex 1 ☐ M		. Age (In yrs.		Mont	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	(Mon	th, Day, Y		Cour		
- 1	Director		577 40 5 Usual Residence o		1 🗆 101	2/LAI	7	8 Yrs	S.			DEC.	31,	1928	3 WASH	INGTON	N, DC
	land ow	}	10a. State	10b. County			10c. Ci	ity, Town o	r Location						1	Od. Inside C	City Limits
	Mary a-f sh fied a	tor	MD	MONTO	GOMERY	ζ.	R	OCKVI	LLE							1 □Yes	s XX No
	th the or 28,	Director	10e. Street and Nu	ımber					10f.	. Zip Code			10g	. Citizen o	of What Cour	itry?	
	ath wi	ral	6105 MON	TROSE 1						2085					D STAT		
	ter de Items ner m	Funeral	<ol> <li>Marital Status</li> <li>Never Man</li> </ol>	ried 2⊟ Mar	1	Armed Ford	ent Ever in U es? ∛0XINo	J.S.	If Yes,	specify Cub	lispanic Origin? (S an, Mexican, Puer	to Rican, et	or No- c.)		Black, White,		
300	I. Z. I 3-UU30 within 72 hours after death with the Maryland ene. than "hatural", or items 23a or 28a-f show than "Medical Examiner must be notified at	by	Widowed		led l	l □Yes f Yes, Give Year or Dat	es:		1 ☐ Ye	es XX No	Specify:			Spe	cify: BLAC	CK	
Č	72 ho natur	Completed	(Spe	15. Deceden	t's Education	n mpleted)		1 (0	Give kind of	Usual Occup	during most of wo	orkina	16	b. Kind of	Business/In	dustry	
5	ithin 7	mple	Elementary/Sec	ondary (0-12)	<del></del>	College (1-	lor 5+)	7 "	re. DO NO	T use retire	d)	9			ND T X / A III I	,	
č	be filed writal Hygiel	Ö	12T 17. Father's Name		l ast)				LPN_		18. Mother's Na	me (First, M	liddle, Ma		RIVATI		
Š	d be dental ked o	To Be	WILLIAM			JS					MILDRE	D KET	TERT	VG.			
5	Add yide filed was and Mental Hygie is marked other time raumatic event, the	-	19a. Informant's N Son ja					19b. N	/lailing Add	ress (Street	and Number or R				vn, State, Zip	Code)	
Ž	if e, INIAT y Idition Z 12 13-0030 s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. If the 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		SANJA T.	GATLI1	NG / I	)AUGH					RIDGE R				MD 207		
3	Dallillore, INIGITYIGIIO Z. IZ. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mertal Hyglien mportant: If item 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Exam once.		20a. Method of Dis		3 □Remo	oval from S		Place of D cemetery,	isposition ( crematory	(Name of or other pla	ice)	Date	20	c. Locatio	n - City or To	wn, State	
	L. Pag tment tant: ijury o	Ι,	4 ☐ Donation	5 Other (5	Specify)			SHING			IAL CEM.				TLAND,		
	Dalumore, Ma permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trea		21. Sonature of F	uvera Service	Licensee	000					FUNERAL						
1			23a. Pa . Enter	the disease, o	r complication	ons that ca	used the dea	ath. Do not	t enter the	mode of dyi	AND ROAD ng, such as cardia	ac or respira	tory arres	ND , P. t,	iD 2074	Approxima	ate
	Physician		Immedia Cause diseas or condition	art failure. List (Final	only one ca	ause on ea	Core	Krou	161501	46	n 9	ecido	s <del>4</del>			Interval Be Onset and	Death
	/Medical		resulting in death)	)	a		r as a conse				7	-/ -/	- 6-1				
3	Examiner	Ļ	Sequentially list of if any, leading to it	onditions,	b	- · · ·											
System	led sit	nine	if any, leading to it cause. Enter Und Cause (Disease o	mmediate lenying - or injury	<b>!</b>	Due to (c	r as a conse	quence or)	):								
	execut n and al-trar	Examiner	that initiated event resulting in death)	ts	c	Due to (c	r as a conse	quence of)	):								
t:/e.7	uch ou, tificate be executed g physician and as the burial-transit	edical E			d												
	rtificat ng phy as th	/ledi	IE EEMALE:														
101	box eath cer attendin for use	lan/l	IF FEMALE: 23b. Was deceded in the past 13			1 ☐Live bi	ome pf pregr th 2 □ Fet	tal death		oic pregnanc	су				Date of delive	ery Day	Year
~~	the a	Physician/M	1 ☐ Yes 🐉 9 ☐ Unknow	₩ No		4∐Pregna 9□Unkno	nt at time of vn	death	5 ∐ Othe	r (specify) _						,	
26	Theconds, F.O. BOX The law requires that the death cer the has been signed by the attendir tage? I should be detached for use	Ph	Part II. Other sign		ons contrib	uting to dea	ath but not re	sulting in t	he underlyi	ing cause giv	ven in Part I.	23e	. Did toba	cco use c	ontribute to t	he cause of	death?
13 G	quires quires n sign lid be	Completed by	(oron	444	Arter	7 1	is ear	se_					1 ☐ Yes	2 □ N	o 3□ Prol	bably 4 🖸	nknown
6	Hecords he law requires has been sign ge 2 should be	olete		•								24a	. Was an	24	4b. Were auto	opsy findings	s available
- 2	The la	mo										10	perform	ed?	death?	2 46	Cause of
7	cian:	Be C	25. Was case refe examiner?	erred to medica						Tau	26. Place of De	eath (Check	only one	)			
2	Or VICA Physician: rthis certific ral director,	은	1 ☐ Yes 2 €		Hosp	onai: 1 ∐ Ir 28a. Date o		ER/Outp		T POA	her: 4 Aursing			ce 6 🗆		fy)	
5	Attending to death.  ctor: After y the funer.	ion	27. Manner of Dea	5 ☐ Pendi invest	ng	(Month	n, Day Year)	Inji		28c. Inju Wo	nyat ork? ]Yes 2∐No	200. Des	scribe nov	r injury oc	curred		
5	I or Attending at er death. Director: Afte	ficat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	28e. Place	of injury - At I	home, farm							ımber or Rur	al Route Nu	ımber,
Gathing,	al or safer	Certification:	4 Homicide	,		buildin	g, etc. (Spec	сіту)				City	or Town,	State)			
3	LIVISION OF VITAI RECORDS, F.O. BOX To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use		29a. Certifier (Check only	1 ☐ Certifyi 2 ☐ Medica	ng Physicia I Examiner:	On the ba	sis of examir	nowledge, nation and/	death occu or investig	irred at the t ation, in my	time, date and plac opinion, death occ	ce, and due curred at the	to the car e time, da	use(s) and te and pla	d manner as s ce, and due	stated. to the cause	e(s)
HA	o the ithin 2 o the o the complet	Medical	one) 29b. Signature an	nd title of certific	er /	and mann				29c. Licens	se number		29	d. Date sig	gned (Month,	Day, Year)	
			- 1	deew	1/	das	MID			Do	036716	•	0	1cto	her 30	200	7
	5		30. Name and add		•		of death (Ite	em 23a) (T	ype, Print)			-		/ -		1	_/
			Andrew	Kude	(rat	14.0,	6/21	1 Mo	ntros	e Roc	036716 ad, Rock	ville	, Me	1. 2	085-	<u></u>	
	Sta Regist		31. Date filed (Mo		1.	32. Re	egistrar's Sign	nature	,		-						
	Regist		NUA O	2 2007	Devel	100	J. 19										
	1 1 1 1 TOV 1/2																

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** v. Guarriello 2007 October 31, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Sunrise Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 1909 156-09-3643 98 Sept. 16, New Jersey Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ō 20901 USA or items 23a 6 Symphony Woods Court Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White by 3 Widowed 4 ☐ Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Law 12 Attorney 27 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental F item 27 is marked ot r other traumatic ever Mary Vagqi Andrew J. Guarriello ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Symphony Woods Court, Silver Spring, MD 20901 Joseph L. Guarriello/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Nov. Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Francis JAdd Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1/2 hour **Physician** Acute Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of): Examiner 14 years Coronary Artery Disease Sequentially list conditions, if any, leading to minimodate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Po Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed þ 1 🗌 Yes a No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ving 2 Certification:

Division or Vital Records, P.O. Box 68760

or Attending Physician; The law requires that the death certificate be executed filled in by the funeral director, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

1 ☐ Yes 2 🔀	No	1 ☐ Inpatient	2 ER/Outpatient	3□ DOA	Otner: 4	☐ Nursing H	ome 5 Residence	6 AOther (Specify)	Facility
27. Manner of Deat 1 Natural 2 ☐ Accident	5 Pending investigation	ł	28b. Time of Injury		c. Injury at Work? 1 ☐ Yes		28d. Describe how in	ury occurred	raciiity
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		- At home, farm, stree Specify)	et, factory,	office		28f. Location (Street City or Town, Sta		Route Number,
29a. Certifier (Check only one)		nysician: To the best of miner: On the basis of ex	amination and/or inve						

and sittle of certifier 29b. Signatur

31. Date filed (Month, Day, Year)

29c. License numbe d13187

29d. Date signed (Month, Day, Year) Nov. 1, 2007

30. Name vid address of person who completed cause of deat (It via 2 a) (Type, Print)

2007

J. Neill Kennedy, MD 5530 Wisconsin Avenue, Chevy Chase, MD 20815

State Registrar

Medical

32 eglstrar's Signature



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Dep	partment of Health and	Mental Hygier	ie	
			1 - State Registrar	ertificate of Death	Reg. N	10.2007	36909
r	BL		1. Decedent's Name (First, Middle, Last)		2. Date of Death	Name of the state	3. Time of Death
	Physici /Medic		Florine W. Gaines			Day Year	7 11:30A <sup>M</sup>
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		c. County of Deat	
			Holy Cross Hospital	Silver Sprin	a	Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	1 0 D:-1	hplace (State or Foreign untry)
B	Director		578-42-0375 1□M 2♥F 75 <sup>Yrs.</sup>	Months Days Flours Wills.	Nov. 22, 1		C
	р ,		Usual Residence of Decedent				
	aryla shov d at	<u>.</u>	10a. State 10b. County 10c. City, Town or L	_ocation			10d. Inside City Limits
	Ba-f	Director		l Heights			1 XXYes 2 ☐ No
	or 2	Ë	10e. Street and Number	10f. Zip Code	10g. (	Citizen of What Co	untry?
	within 72 hours after death with the Maryland piene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Funeral	1008 Carrington Avenue	20743		ited St	
	er de Items	une	Armed Forces?	<ul> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ul>	pecify Yes or No- to Rican, etc.)	14. Race - Amei Black, White	
36	s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ※ No If Yes, Give 3 ※ Widowed 4 □ Divorced Year or Dates;	1 ☐ Yes 2 🛣 No Specify:		Specify:	
2-003	hour tural	d b		adaaka Harral Ooroo ka		Bl	ack
	"nat	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired)	rking 16b.	Kind of Business/I	Industry
12	within ene.	ဋ	Elementary/Secondary (0-12)   College (1-4or 5+)	Punch Supervis	į.		
12 p	it it je	Š	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide		vernment
ä	e   e   e	Be C	William Anderson			iii Guinaine)	
Maryland	ss 1 and 2 should be filed of Health and Mental Hygi item 27 is marked other rother traumatic event, t	မ		Elmira ling Address (Street and Number or Ri	Mazone	cor Town State 3	Vin Code)
<u>8</u>	d 2 s thar thar 7 is trau		Wanda Gaines/daughter 100	8 Carrington A	venue	or rown, state, z	up Code)
a)	1 and 1 Health em 27 other tr			8 Carrington A Dital Heights,	MD 20743 Date 200	Location - City or	Town State
Baitimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)		•	
	it. Purtue		4 □ Donation 5 □ Other (Specify) Ft. Lin  21. Signature of Funeral Service Licensee	coln Cem. 11/	15/07 Br	entwood	, Md.
g	Depa Impo any i		21. Signature of Purietal Service Licensee	22. Name and Address of Facility Ho	odges & E	dwards	F.H.
			23a. Party Enter the disease, or complications that caused the death. Do not er			itiand,	
			shook, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardial	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Sepsis				
	/Medical Examiner		Due to (or as a consequence of):				
	PLIN'	_	Sequentially list conditions, if any, leading to immediate  b. Renal Failure  Due to (or as a consequence of):				
4	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause Disease or injury  b. Reflat Fatture  Due to (or as a consequence of):			:01	
9	ecut and I-trar	xan	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8/60	be e	田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	250 10 (0" 00 10 00 00 00).				
ğ	icate be executed physician and s the burial-transit	dical	d				
×			IF FEMALE: 23c. If yes, outcome pf pregnancy				
ž 2	atten for us	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	□Ectopic pregnancy	N .	23d. Date of deli-	very Day Year
j.	the a	ysic	1 ☐ Yes 2 <b>M</b> No 4☐ Pregnant at time of death 5 9 ☐ Unknown 9 ☐ Unknown	Other (specify)			
ı	law requires that the death certif as been signed by the attending 2 should be detached for use a	문	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tohacco	use contribute to	the cause of death?
ecords,	sign d be	by	Esophagus Necrosis			2  No 3  Pro	
Ö	requ	etec	Booking as Trectosis				obably ( Eleminous)
ě	a	Completed			24a. Was an autopsy	prior to c	topsy findings available completion of cause of
VII III	: Th	Ö.			performed? 1☐ Yes 2 ☑ N		2 <b>₽</b> No
Z Z	ician Sertifi ector	Be	25. Was case referred to medical examiner?		th (Check only one)		
0	hysi this c	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	T THAI SING T	ome 5 Residence		city)
_	ing F After unera	on:	27. Manner of Death 1 Manural 5 □ Pending (Month, Day Year) 28b. Time of (Month, Day Year)	Work?	28d. Describe how inj	ury occurred	
UNISION	tend eath. tor: / the fi	Certification:	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	ter d	ŧ	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
ב	urs al						
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only (Check only (Check only (Check)) (Check only (Check)) (Check only (Check)) (Check only (Check)) (Check only (Check)) (Check	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the cause (rred at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	the the the the the the the the the the	Med	and manner stated.	29c. License number			
	No No No No No No No No No No No No No N		29b. Signature and title of certifier		i	ate signed (Month	
•			Bully / Un	D 36631	[1]	, 11, 2	2007
	01		30. Name and add ess of person who completed cause of death (Item 23a) (Type				
			Kevin Lurie 2121 Modical Park 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Drive, Silver	Spring, M	d. 2090	2
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	104/1			
	THE REAL PROPERTY.	1	A Property of the second secon				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Cora Viola Givens October 30, 2007 2:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Rehab. and Nursing Center Burtonsville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Yrs. Director 149-20-5288 93 Virginia March 20, 1914 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Directo Virginia Prince William Woodbridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 1900 Caroline Court 22191 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours efter 1 ☐ Yes 21/21/20 If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No þ Specify: Specify: Black 3 € Widowed 4 Divorced natural. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Heelth and Mental Pages 1 end 2 should be Isaac Powell Bessie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene G. Givens/Son 1900 Caroline Court, Woodbridge, VA 22191 Date 5, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If its
eny injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glendale Cemetery 2007 Bloomfield, New Jersey 21. Signature of Funeral Service Licensee Francis Addess Collins Funeral Home Inc. aus. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cerebrovascular Dise /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown C2 Fracture Secondary To Fall, Failure To Thrive Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed 1 ☐ Yes 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To his 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending To the Hospman after death.
To the Funeral Director: Aft 1 Tes 2 XNo investigation unk M 2 XAccident Sept. 2, 2007 Tripped and fell 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 901 Arcola Avenue, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide nursing home-Arcola Health & Rehab. Silver Spring, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 5, 2007

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

3

Box 68760,

P.0.

Division of Vital Records,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8

28 35

32. Segistrar's Signature

			1 - State of Maryland / Dep	partment of Health and Mental Hygien 0 0 7 Page No.	36911
3	° Physici /Medic		1. Decedent's Name (First, Middle, Last) Elsie Hearst	2. Date of Death Month October 31, 200	3. Time of Death 6:15 AMM
	Examin		4a. Facility Name (If not institution, give street and number) Summerville Assisted Living	4b. City, Town, or Location of Death Potomac 4c. County of D Montgo	
-	. Funeral Director		5. Social Security Number 497-01-9086 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 93 Yrs.	y) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9.  Months Days Hours Min. December 31, 1913	Birthplace (State or Foreign
	Maryland 9-f show	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or           MD         Montgomery         Rockvil		10d. Inside City Limits 1 □ Yes 2 □ No
	th with the 23c or 28c	ai Director	10e. Street and Number 7 Farm Haven Court	10f. Zip Code 10g. Citizen of What 20852 United St	*
36	72 hours after death with the Maryland natural', or Itams 23c or 28e-f show disal Examinat rust be rigitified at	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:		merican Indian, /hite, etc. White
Maryland 21215-0036		Completed	(Specify only highest grade completed)  (Gi    Elementary/Secondary (0-12)   College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)  memaker  Own Ho	
land 5		To Be Co	17. Father's Name (First, Middle, Last)  Nathan Gollub	18. Mother's Name (First, Middle, Maiden Sumame) Macha Malcolm	Jii C
Mary	2 sh and Is m			iling Address (Street and Number or Rural Route Number, City or Town, Stat	e, Zip Code)
Baltimore,			20a Method of Disposition 20b. Place of Dis	rm Haven Court Rockville MD 20852  position (Name of rematory or other place) adisha    Date   20c. Location - City	
Balti	permit. Page Department of Important: if any injury or once.			22. Name and Address of Facility  dward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville N	
8760,	Physician /Medical Examiner	dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	VE PULMONARY DISEASE	Approximate Interval Between Onset and Death
.O. Box 68	at the death certificate be executed by the attending physician and tached for use as the burrat-transit	Physician/Med		B ☐ Ectopic pregnancy B ☐ Other (specify)	delivery Day Year
Δ.	uires that signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the DEMENTIA		e to the cause of death?  Probably 4 Unknown
l Records,	The law requires that ate has been signed be page 2 should be deta	Completed	OSTEOARTHRITIS		
on of Vital	ng Physicien: Iter this certific neral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2  No	of 28c. Injury at 28d. Describe how injury occurred	Assisted Specify)
Division	Attan ar deat actor: by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury : At home, farm, building, etc. (Specify)		r Rural Route Number,
	Hospit 4 hour Funare ely fille	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the cause(s) and manne investigation, in my opinion, death occurred at the time, date and place, and	due to the cause(s)
-		M	29b. Signature and title of certifier  Agens	29c. License number $29d.$ Date signed (M $D64578$ October $31$	
			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Mehooda Naeem 15225 SHADY GROVI	e, Print) E RD, ROCKVILLE, MD 20850	
ŀ	Sta Registr		31. Date filed (Month, Pay, Year) 2007 Registrar's Signature	new in the second	

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:38 2, 2007 November /Medical MARY D HORNER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Director 220-28-3938 75 April 12,1932 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov ury or other traumatic event, the Medical Examiner must be notified at XXYes 2□No Directo Maryland Frederick Thurmont 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 37 Frederick Road Funeral 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>۾</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Supervisor Textile 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Staub 2 Kathleen Woolard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trai Donald M. Horner/Husband 37 Frederick Road, Thurmont, Md 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November Stauffer Crematory 6, 2007 Frederick, MD 21. Signature of Furneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical as the attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform certificate 2 No Hospital or Attending Physician: Be filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA L<sub>O</sub> after death.

Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral Completely filled 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 400 W. Seventh Street, Frederick, MD 21701 M. Raza 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar NOV 0 6 2007

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** October Sandra May Harris 2007 1:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 1 F 219-44-2998 Director 61 Feb. 6, 1946 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Adamstown Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 1838 Pleasant View Road 21710 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 🗙 No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☒ No Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Williams ဂ Jessie Mae Herbert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trauonce. Howard E. Harris, Sr. / Husband 1838 Pleasant View Road Adamstown, Maryland 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5, 4 □ Donation 5 □ Other (Specify) Sunnyside Cemetery 2007 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of F Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) achero Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-trar and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 21 No 1 🔲 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? (Month, Day Year) 5 Pending investigation Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basic of examination and/or investigation in my salidar data. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

Robert L. Kaufmann, M.D.

29b. Signature and title of pertific

29d. Date signed (Month, Day, Year)

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

300 W. Ninth Street Frederick, Maryland 21701

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 6 2007

29c. License number

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) **Physician** /Medical **Examiner** Dove House 5. Social Security Number 6. Sex **Funeral** Director 220-26-7435 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmoortant: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. the Medical Examination. 10b. County Directo 10e. Street and Number 507 Riggs Court by Funeral 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed Elementary/Secondary (0-12) 7th 17. Father's Name (First, Middle, Last)

Certificate of Death Reg. No. 2 2. Date of Death Month 2-2007 12:36 A<sub>M</sub> Marian Elizabeth Hossler 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-18-1929 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1 □ M 2 □ Maryland 78 10c. City, Town or Location 10d. Inside City Limits Frederick Frederick 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 21703 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☑ No Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Clerk Drug Store 18. Mother's Name (First, Middle, Maiden Surname) Be Herman J. Grim Alice S. Grabill ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Jill Rosner/Daughter 1615 Goldsmith Dr. Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 11-05-2007 Woodsboro, Md. 21. Signature of Fureral Service 22 ROBERT ddres of Dairley & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701 23a. Part1. Enter treasease, or complications of to shock, or heart failure. List only one cause in ea Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Due to r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 mo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ufficant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 3 Probably 4 Unknown Completed 2NoreMIP Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 2 □ Ng ို 1 🗌 Yes 2 ER/Outpatient 3 DOA ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of L 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ural 5 ☐ Pending investigation 1 Yes 2 No Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 2 ☐ Medical Examine one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Nonth, Day 32. Registatr's Signature State

**Physician** /Medical

**Examiner** 

for use as the burial-tra

signed by t. d be detach

pace 2 should

funeral director,

After this

nin 24 hours after death the Funeral Director;

physician

lay requires that the death certificate be executed

or Attending Physician:

Hospital

Division or Vital Records, P.O. Box 68760,

		,	For State Registrer	State of Ma	ırylan				ealth a	nd M		giene	7	36915
E	Physici	an	1. Decedent's Name (First, Middle, Las	*	Hudso						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Marian Mil  4a. Facility Name (If not institution, give		luuse	711	4b City	Town or	Location of	f Death	Octobe	4c. County	2007	20:47 M
1	Examin	ier	Pininsyum Regiona		. Ce	enter	10. 0.,		136414				cune	
	Funeral Director		5. Social Security Number 218–16–5634 6. Sr		(In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day 3/23/1	h, Y, Ye <i>ar)</i> 922	Cour	place (State or Foreign cryland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation						1	0d. Inside City Limits
	Mary a-f eh	tor	Maryland Wicomic	:0	Sal	isbury	7							1 ☐ Yes 2 🛣 No
	h with the 23a or 28a st be not	Funeral Director	10e. Street and Number 9288 Hickory Mill	. Road				Code 1801				10g. Citizen of USA		ntry?
36	d within 72 hours after death with the Maryland Jene. r then "naturel", or itema 23a or 28a-f ehow the Madical Examinat must be natified at	by Funer	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:			Was Dece If Yes, spe 1  Yes	cify Cuba	spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		ce - Americ ck, White,	etc.
2-0	72 hou	ted	15. Decedent's Ec	lucation		16a. Dece	dent's Usu	ai Occupa	ation fu <i>ring m</i> ost	of works	20	16b. Kind of B	usiness/In	dustry
21215-0036	within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	ôö võtî ≥make	ise retired	)	OI WOIKII	, g	Dome	atio	
d 2	be filed v ita! Hygie id other t		17. Father's Name (First, Middle, Last)			поше	smake	L	18. Mother	r's Name	(First, Middle,	Maiden Suman		
an	be d ta	To Be	King B. Miller S	ir.					Man	rian	Sterli	ng		
, Maryland	nd 2 she lith and 27 is m r traum		19a. Informant's Name/Relationship (Raymond Hudson J				-					bury, M		
Baltimore,	of Hee		20a. Method of Disposition  1 🔀 Burial 2 🗆 Cremation 3 🗆	Removal from State		lace of Dispo emetery, crea	natory or	other place			ate	20c. Location		
tim	t. Pag ntment ntant: njury o		4 ☐ Donation 5 ☐ Other (Specify	<b>-</b>		irk				11/6,		Salisb		
Bal	permit. Pages. Department of H important: If ite eny injury or ot once.		21. Signature of Funeral Service Liven	euroy C	SP		OUT S	now I	4111	Ra.,	Salisb	ury, MD	al As 2180	
	Physician		23a. Part1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused one cause on each lin	the death		_		g, such as d			rest, DISEAS	5	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ				,		•			
0,	ate be executed hysician and ine burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a Due to (or as a										
68760	ohysici	dical	•	d	,			•						
.O. Box 6	that the death certificate to the by the attending physic detached for use as the to the the the the the the the the the the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 √ Yo 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3	Ectopic p						ite of delive	ery Day Year
<u>α</u>	uires that the signed by the detaction	by	Part II. Other significant conditions of		ut not resi	ulting in the u	nderlying	cause give	an in Part I.			obacco use con res 2 No		he cause of death?
Records,	The law requires that the rate has been signed by th page 2 should be detache	ompleted	SICK SINUS	. Sini	RON	15						rmed2	Were autoprior to codeath?	opsy findings available impletion of cause of
Vital		Bec	25. Was case referred to medical examiner?			1			26. Place	of Death	Check only o	To a real part of the last of		2,000
of <	S S	၉	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier			4   Nul			dence 6 Oth		(y)
סח	ding h. After fune	tlon	1 T∩atural 5 Pending	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	M	28c. Injury Work	rat c? Yes 2 □ N		28d. Describe r	now injury occur	rea	
Division	I or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		ury - At ho	ome, farm, str					28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the	ledical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best on niner: On the basis of and manner sta	examina	wledge, deat tion and/or in	h occurred vestigation	d at the tim n, in my op	ne, date <i>a</i> nd pinion, deat	d place, a	and due to the	cause(s) and m date and place,	anner as s and due to	stated. the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	,			29	c. License	number			29d. Date signe	d (Month,	Day, Year)
)	c M.		Mulle	der		MI		Po	060	5/5	5	101	27/0	27.
	DA.		30. Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	DE	00	di A s	E D D .	,	יו	Dal.
Sales Sales	Sta Registr		31. Date filed (Month, Day Year) 0 2	2007 32. Regi	ar's Signa	ture #	Spa	KC !	1/4,	MLI	SBURY	14	y Z	1804.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10 2007 November Leona Iden /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year) Days Hours 1 ☐ M 2 💢 F October 31, 1932 75 215-42-3689 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 1X Yes 2 □ No Director Washington Hancock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21750 **USA** 6115 Sensel Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Miller ပ Lester Gantt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13761 Worleytown Road Greencastle, PA 17225 Gloria J.Snider/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/13/2007 Big Cove Tannery, PA Damascus Cemetery 21. Signature of Funeral Service. 22. Name and Address of Facility 141 West Main Street 5 Grove Funeral Home, P.A. Hancock,MD 2<u>1750-0368</u> 23a. Part1. Enter the disease, or commend that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYONIC **Physician** /Medical Due to (or as a consequence of): Examiner etabol. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed OYONXYY attending physician and for use as the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760, bit Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 mor Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ate has page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 2 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification:

or Attending Physician: funeral director, After this Division after death. the filled in by

To the Hospital within 24 hours a To the Funeral I

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Hagerstown Maryland

State Registrar

Medical

Murshed 31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Opay Registrar's Signature

**Funeral** 

Director

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Veal Physician Month Thomas Harold Johnson 9:33 P. M November 11, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Days Months 1**∑**M 2□F 05/21/1946 220-42-1842 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 1 ☐ Yes 2 No MD Calvert St. Leonard 10f. Zip Code 10g. Citizen of What Country? 5736 Oakcrest Drive 20685 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Folces: 1 My Yes 2 □ No If Yes, Give Year or Dates: Vietnam 1 ☐ Never Married 2 😾 Married 1 ☐ Yes 2**%** ☐ No Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing / Procurement Nuclear Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Lillian Gibson Clagett Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine J. Johnson (Wife) 5736 Oakcrest Drive, St. Leonard, Maryland 20685 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul UMC Cemetery 11/16/07 Lusby, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🔟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) Emad A1-Banna MD 1050 Solomons Island Road, North, Prince Frederick, MD 20678 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 19

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State o	f Marylan		artment rtificate				lental Hyg	gienę.	7 / 1 / 1	7	36918	3
Г	Physici	an	1. Decedent's Name (First, Midd								2. Date of Dea Month October		200 Yet	ər	3. Time of Death	_
	/Medio		Yalice 4a. Facility Name (If not institution	Kamara	mber)		4b. City.	Town, or	Location of		october		2007 County of D	I	10:20 p M	_
	LAAIIII	iei	Greater Laure			. Ctr		ure1					rince		orges	
	Funeral		5. Social Security Number	6. Sex 1  M 2  F	7. Age (In yrs.		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 9	h v, Year)	9.1	Birthpla Counti	ra Leone	n
	Director		579-13-4025 Usual Residence of Decedent	X.	8	O Yrs.					Aug. 9	, 19	2/ 5	iler	ra Leone	
	ryland how	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10	d. Inside City Limits	
	he Ma 18a-f s	Director		Arunde1		Laure					1				Yes 2 No	1
	with t	DI	10e. Street and Number 3354 Crumptor	n South			10f. Zip	724				-	en of What erra I		-	
	death	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	. 1	4. Race - A			
36	s after , or Ite	by Fu	1 Never Married 2 Mai	rried 1 ☐ Yes If Yes, Giv	2 <b>X</b> No		1 ☐ Yes 2		Specify:	i, Fueito	rican, etc.)		Black, W Specify: I			
Ö	2 hour	ed p	3 Widowed 4 ☐ Divorced	Year or D	ates:	16a, Dece	dent's Usua	I Occupa	tion				id of Busine			
212	thin 72 e. en "ne	Completed		est grade completed) College (1	-4or 5+)	(Give life.	kind of wor DO NOT us	k done d e retired)	uring mosi	t of worki	ing		e1f-Em		•	
2	fled wi	Con	0 17. Father's Name (First, Middle,			Hou	sewif	e	40.14.15		(F: ) 14:4 (I			трто		_
Maryland 21215-0036	2 should be filed within 72 hours after death with the Manyland and Mental Hygiene. Is marked other then "neturel", or Items 23s or 28s-f show surmatic event, the Medical Externing register prolified at	To Be	Foday Kamara								e (First, Middle, Sesay	Maiden .	Sumame)			
Mar	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relations Sally Kamara	ship <i>(Type, Print)</i> (Daug	hter)		ng Address Henr				Laure1				Code)	
Baltimore,			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$		State	lace of Dispo emetery, crer Family	natory or ot	her place			) / 2007	Sier	ra Le th Af	one		
Balt	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service	icensee Ba	ICON CL	361	. Name and 3447	Addres 14th	s of Facility	W.	H. Baco N.W. Wa	on Fu ashii	neral	Ho DC	me, Inc. 20010	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that c t only one cause on e	aused the death ach line.	n. Do not ent	er the mode	of dying	, such as	cardiac c	or respiratory ar	rest,			Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	d	betes											
H	Examiner				oras a consequ ipheral		lar D	isea	se							
	· ·	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequ						·					
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c	or as a consequ	uence of):								+		
9/60	death certificate be executed e attending physician and of for use as the burial-transit	dlcal E		L a												
Õ	rtificate ng phys as the	Medi	IF FEMALE:													_
XOX	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		irth 2 🗆 Fetal	death 3	Ectopic pre					2	3d. Date of Month		/ Day Year	
o.	at the de by the a	ysic	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unkno	ant at time of de	eath 5	Other (spe	ecity)								
2	requires that the een signed by th nould be detache	by Pr	Part II. Other significant conditi	ons contributing to de	ath but not resu	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco us	e contribute	to the	cause of death?	
ecords,	w require been sig should b	ted !	Stroke								1 🗆 Y	es 2	]No 3□	Probal	oly 4 🖄 Unknown	
ě	aw as b	Completed	Hypertension								24a. Was a autop	sy	24b. Were prior 1	autops to comp	y findings available pletion of cause of	,
VITAL H	Th ate pag	e Col	OS Man accessorate modica								perför 1 ☐ Yes	2 🔯 No	1 🗌 Y	es 2	□ No	
	Physician: this certific al director,	0 0	25. Was case referred to medica examiner?  1 ☐ Yes = 2 ☑ No	Hospital:	npatient 2	ER/Outpatien	t 3 🗆 DO	Othe			n <i>(Check only or</i> me 5 ☐ Resid		Other (S	necifu)		
on or	ing	tlon: T	27. Manner of Death  1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	28a. Date of	of Injury h, Day Year)	28b. Time of Injury		lc. Injury Work		2	28d. Describe h			poony		
DIVISION	spitel or Attending Fours after death.  erel Director: After filled in by the funera	ertification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	eet, factory,			-	28f. Location (S City or Tow		Number or	Rural	Route Number,	_
	Hospite 4 hours Funere ely fille	edical C	29a. Certifier 11 Certifyir (Check only one)	ng Physicien: To the Exeminer: On the ba and mann	isis of examinat	wledge, death ion and/or inv	occurred a	t the time in my opi	e, date and inion, deat	d place, a	and due to the c ed at the time, c	ause(s) a late and	and manner place, and o	as stat	ted. he cause(s)	
	To the Vithin 2 To the Complet	Me	29b. Signature and title of certifie		~		29c.	License	number		2	29d. Date	signed (Mo	onth, Da	ay, Year)	
			1 (Jann	lle	C			0053	235			Oct	. 31,	200	)7	
_	(4)		30. Name and address of person Darryl Hill,	$ \stackrel{\text{who completed caus}}{\text{M} \cdot \text{D}}   1 $	of death (Item 3635 Ba	23a)(Type, 1timor	Print) e Ave	• •	Laure	e1, 1	Md. 207	07				
	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 0 2 2007	heren 32. Re	egistrar's Signa	ure										

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year /Medical Josiah Ashton Kesler 05 07 7:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clinton, MaryLan If Under 1 Year | If Under 24 Hrs. Southern Maryland Hospital Maryland 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Hours X M 2 □ F 71 Director 12-31-35 VΑ 228-38-9563 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√☐ No Director VA Henrico Richmond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2400 Homeview Drive 23294 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 騺 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 🍇 ☐ No Specify: White ģ 3 ☐ Widowed 4 🔯 Divorced ube filed wn. dental Hygiene. dother than "natu. 't, the Medical Ey. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychologist Health Care 6 permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Josiah Daniel Kesler Lola Tebbs ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Malcolm Scott Kesler/Son 2400 Homeview Dr., Richmond, VA 23294 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11020 WEST BROAD STREET 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State BENNETT CREMATORY 11/08/2007 4 ☐ Donation 5 ☐ Other (Specify) GLEN ALLEN, VIRGINIA 0502900233 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11020 WEST BROAD STREET BENNETT FUNERAL HOME GLEN ALLEN, VIRGINIA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final erebro VOSC **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine sician and buríal-transit certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buría Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ed by the a 9 Unknown 9 Unknown sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate Division or Vital 1∐ Yes 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🔲 Yes 1 \_\_\_\_npatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne Death 28b. Time of 28c. Injury at Work? After I Certification: 1 4 atural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determine 4 Thomicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending within 24 hours a

> State Registrar

Medical

29a. Certifier (Check only one)

29b. Signature

31. Date filed (Month, Day, NOV 1 2007 32 Registrar's Signature

and manner stated.

(Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

he SE #701 WDC POOSZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month EVA E. LEVINE 10/29/2007 B:20 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sev 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 1 □ M 2 1 1 F 87 020-09-9436 12/31/1919 MA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director ty Yes 2 No MD MONTGOMERY KENSINGTON 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 3616 LITTLEDALE ROAD 20895 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: WHITE Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERICAL U.S. GOVRNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MORRIS LEVINE ROSE GLUGETH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES F. LEVINE - SISTER 3616 LITTLEDALE ROAD, KENSINGTON, MARYLAND 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARDEN OF REMEMBRANCE 11/01/2007 CLARKSBURG, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature In une Service Licensee 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE Due to (or as a consequence of) HYPERKALEMIA Sequentially list conditions, it and Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a conse wence of CLOSTRIDIUM DIFFICILE COLITIS Due to (or as a consequence of) Physician/Medical HYPOTENSION 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2 ☒ No Month Day 4□Pregnant at time of death 5 Other (specify) a I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERIOSCLEROTIC HEART DISEASE 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed FAILURE TO THRIVE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? DEMENTIA 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ▼ No 1 Xnpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

**Physician** /Medical Examiner

**Funeral** 

Director

a or 28a-f show be notified at

frems 23a ciner must by

"natural", or Items edical Examiner n

the Medical

traumatic

co

: If item 27 i

permit. Page Department of Important: If any injury or

filed within 72 hours after death with

Duld be f

Pages 1 and 2 should I

Baltimore, Maryland 21215-0036

for page 2 should

Hospital or Attending Physician: filled in by the

24 hours after death Funeral Director: within 2

Certification: To 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and le of certifier 29c. License number D53691 OCTOBER 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AJAY REDDY, 6320 DEMOCRACY BLVD, BETHESDA, MARYLAND

State Registrar 31. Date filed (Month, Day Year) NOA 02

Registrar's Signature

DHMH 17 Rev 1/2001

Amend Item 26 per verb., go /4-12/7/07dhb Reg. No. 36921 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician GRACE** LITCHFORD 10-31-2007 Ε. /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 211 Spruce St Wicomico Delmar 8. Date of Birth (Month, Day, Year) 07-09-1913 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 💢 F 94 Yrs Director 221-32-3140 Virginia Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours effer death with the Marylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Delaware Sussex Seaford 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 21475 Atlanta Rd 19973 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specify: white þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Home Owner 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be A. K. Venable Maida Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

11143 Line Rd, Delmar, DE 19940
Date 20c. Wayne Litchford - son 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Odd Fellows Cemetery 11/04/07 4 ☐ Donation 5 ☐ Other (Specify) Seaford, DE 21. Signature of Funeral Sovice Licenses 22. Name and Address of Facility Cranston Funeral Home John 4 Cranston P O Box 967, Seaford, DE 19973 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MIND Examiner Physician/Medical Examiner Congettive Heart Failur MTRS attanding physician end I for use es the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): YL3 Stawm Division of Vital Records, P.O. Box 68760. UKTIC Due to (or es e consequence of): resulting in deeth) Lest seta has been signed by the a paga 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Kikullalia ģ 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy performed? certificeta has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: tha funerel director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother Sitter's House Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 After this 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Hospital 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end manner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end manner steled. 29a, Certifier edicai completaly 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number MO DOWALD M. WOOD 07 30. Neme end address of person who completed cause of d eth (Item 23e) (Type, Print) Eastern Stine 31. Dete filed (Month, Day, Year) 32. Regis ar's Signature NOV 0 2007 Registrar

DHMH 16 Rev 6/95

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 36922 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 3Pay, 2007ar 7:10 A M Lois Ζ. Margolis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maple Hill Assisted Living Howard Laurel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 92 1 □ M 2 X F Director May 25, 1915 PA 276**-**14**-**5444 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at MD Howard Laurel 1 □Yes 2 □XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10711 Harding Road 20723 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Fashion Designer</u> Fashion or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Leach Halle Metcalf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 16636 Cutlass Drive Rockville MD 20853 Shelly Silverstone – Stepdaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/4/07 Judean Memorial Grdns Olney, MD 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) 10 **Physician** Chronic Obstructive Pulmonary Disease years /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Dementia 3 years and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 24 No Month 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: ASSISTED ASSISTED Hospital: Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural
2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director; 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and tip of certific 29d. Date signed (Month, Day, Year)

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Elliott Gorbaty, MD 1411 Madison Park Drive Suite 2B Glen Burnie MD 21061 31. Date filed (Month, Day, Year) egistrar's Signature NOV 0 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Of Maryland		tificate of Death		g. No. 2007	36923
ξ.	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Betty L. Mackenzie  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location o		r 1, 2007 4c. County of Death	12:10 A <sup>M</sup>
	Examin	ier	319 East Potomac Street		Brunswick	n Bodui	Freder	
and it	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 1 M 2 京 7. Age (In yrs. last 1 M 2 ) Age (In yrs. last	t birthday). Yrs.	If Under 1 Year If Under 2 Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, ) Feb. 6,1	Year) 9. Birth	place (State or Foreign ntry) yland
	yland row at		10a. State 10b. County 10c. City, T	own or Lo	cation	<del></del>		10d. Inside City Limits
	e Mau Ba-f sl atified	Funeral Director		swick				1 X Yes 2 No
	vith th	Dire	10e. Street and Number		10f. Zip Code	109	g. Citizen of What Cou	ntry?
	eath v	eral	319 East Potomac Street  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	21716 Vas Decedent of Hispanic Orio	nin? (Specify Yes or No-	United St	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	b	Armed Forces?  1 ☐ Never Married 2 ☐ Married		Vas Decedent of Hispanic Oriof f Yes, specify Cuban, Mexican ☐ Yes 2☑ No Specify:	, Puerto Rican, etc.)	Black, White,	
2-0	72 hc 'natul dical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupation kind of work done during most DO NOT use retired)	t of working	6b. Kind of Business/In	idustry
121	within ene. <b>than</b> '	dmo	Elementary/Secondary (0-12) College (1-4or 5+)				Name of the second	
d 2	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)	Cer	tfied Nurses A	r's Name (First, Middle, Ma	Nursing aiden Surname)	
Maryland	Jenta Jenta rked tic ev	To B	Harry H. Smith		Ella	Mae Orem		
lary	2 sho and N Is ma			19b. Mailin	g Address (Street and Numbe	er or Rural Route Number,	City or Town, State, Zij	o Code)
	1 and 2 Health tem 27 I				ast Potomac St			
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest	haven	sition (Name of natory or other place) Memorial Ga'ro	dens11/6/07 1		Maryland
Bal	permit Depar Impor any In		21. Signature of Juneral Service Licensee	/ 1	. Name and Address of Facility 100 N. Maple A	Ave., Brunswi		
в			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dying, such as	cardiac or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	neu	maria			1WEEK
	Examiner		Due to (or as a consequer	ice of):				
li	*	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitiated events	nce of):				
	ecuted nd transit	Examiner	Cause (Disease or injury that initiated events coulding in death) Last					
60,	tificate be executed ig physician and as the burial-transit	EX	Due to (or as a consequer	ice of):				
68760,	icate physics the t	ledical	d					
P.O. Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
	w requires that s been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting the significant conditions.	ng in the ur	nderlying cause given in Part I.	23e. Did toba	acco use contribute to t	the cause of death?
Division or Vital Records,	stcian: The law re s certificate has bee irector, page 2 shou	Completed by	chronic obstructive	(nng	D'sease	performe	prior to co	opsy findings available ompletion of cause of
/ita	Physician: r this certifica ral director, p	Be C	25. Was case referred to medical examiner?			of Death (Check only one)		
or V	> .∞ ₽	은	1  Yes  Par No  Hospital: 1  Inpatient 2 ER				ice 6 □Other (Speci	fy)
ono	iding Physian. In: After this funeral di	tion:	27. Manner of Death  1 ★Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury at Work?  M 1 ☐ Yes 2 ☐ N	28d. Describe how	/ injury occurred	
Divisi	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowle and manner stated.					
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Month,	Day, Year)
			Hiron of 5ho	h	0516	43	11.1.07	
	5		30. Name and address of person who completed cause of death (Item 23)  31. Date filed (Month, Day, Year)  32. Registrar's Signature  NOV 0 6 2007	3a) (Type, I	Print)  President	dences n	nd 217	02
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signatur	of A	Conti			

07-08482 Vernon Miles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rnon Miles		State of Maryland / Department of Health and Mental Hygiene  - For State  Certificate of Death  - Peo No. 2007 3692
Physici		Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
edical Exam		VERNON W. Miles November 1, 2007 Year 0342 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Peninsula Regional Medical Center  Salisbury  4c. County of Death  Wicomico
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director		220-10-6965 1 Mm 2 F 90 Yrs. Months Days Hours Min. 6-22-17 Foreign Country) VA
,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
d now an		VA ACCOMACK HORSEY
arylan 8a-f sk at onc	cto	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
the M sa or 2	اقّا	27396 HOKSEY KOORD 23396 USA
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
ŏ 5 8	Ē	3 Wildowed 4 Divorced If Yes 2 No specify: Specify: White
ours af atural samin	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
36 n 72 h nan "n ical E	ole te	Elementary/Secondary (0-12) College (1-4 or 5+)  Book Keeper  CANNING
215-0036 be filed within 7 mtal Hygiene. rked other than eut, the Medics	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
215 be file ntal Hy rked o	Be	James Paige Miles Josie Hickman
Baltimore, MD 21215-0036  permit. Pages I and 3 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente. Important: If liter a 72 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.	유	19a. Informant's Name/Relations (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 sho lealth and item 27 is		20a. Method of Disposition
nore		1 Description 3 Removal from State Crematory or other place) 4 Description 5 Other Specific Company of the Specific Company of
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fox FUNCES #COME
		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approximate Interval
Physician Medical		failure. List only one cause on each line.  Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  A Multiple Injuries with Complications  Due to (or as a consequence of):
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	Cause. Enter Underlying Cause (Disease or injury that Initiated C.
ted J unsit	Exa	events resulting in death) Last  Due to (or as a consequence of):
50, te be executed ysician and burial - transit	edical	UNPENDED AMENDED
68760, certificate be nding physicise as the burit	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1
Box 6876  death certificate the attending phy ed for use as the	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year  4 Pregnant at time of death 5 Other (Specify)
BO)  e deatl  the att	Physician/M	1 Yes 2 No 9 Unknown g Unknown g Unknown  Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
, P.O. Box 6876 ires that the death certificat signed by the attending phy lbe detached for use as the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ords, w require is been sig	Completed	24a. Was an 24b. Were autopsy findings available
COOF te law i te has t	du	autopsy prior to completion of cause of performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal Recoluin: The law certificate has ector, page 2 sl	Be Co	25. Was case referred to medical 26.Place of Death (Check only one)
of Vital Records, ing Physician: The law requir wher this certificate has been s meral director, page 2 should l	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other:
n of ding Ph		27. Manner of Death  28a. Date of Injury (Menth, Day ear)  1 Natural 5 Pending  28a. Date of Injury (Month, Day ear)  1300 hrs  28b. Time of Injury 1300 hrs  28c. Injury at Work? 1 Yes 2 V No  28d. Describe how injury occurred  Passenger auto auto collision
Division tal or Attendi rs after death. al Director: A	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Division of Vital I Rospital or Attending Physician: 44 hours after death. Funeral Director: After this certifi Funeral by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide could not be determined (Specify) Street or Town, State) 28275 Horsey Road, Oak Hall, VA
Di To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To th within To th	Medical	2 Medical Examiner: On the basis of examination another investigation, in try opinion, death occurred at the time, date and prace, and doe to the cause(s)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		O.C.M.E. November 2, 2007
2.0		30. Name and address of person who completed cause of death (Item 23a)
BAIO		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Regi	State	31. Date filed (Month, Day, Year) 5 2007 32. Restrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 21,  $P^{M}$ October 2007 8:20 Loretta D. Malone 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 2700 S. Haven Road Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 1 □ M 2 🗓 F 79 1928 307-22-4608 **Director** Indiana May 11, Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Director Maryland| Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in USA 21401 2700 S. Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 12 should be filed w h and Mental Hygie 7 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verna Kochanowski ပ Peter Wroblewski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important; If item 27 is n any Injury or other traur 10 Fairhope Court Annapolis, MD 21403 J. Michael Malone/ Son 20b. Place of Disposition (Name of cometery, crematery or other place)
Maryalnd 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/26/2007 Crownsville, MD Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home Ciela 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a co **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-tran Due to (or as a consequence Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 → No 3 Ectopic pregnancy ļo Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 Accident

Division or Vital Records, P.O. Box 68760 attending physician ate has been signed by the page 2 should be detached this Hospital or Attending death. Director To the Hospital of within 24 hours af To the Funeral D

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIZER MIGGINEE MD 1667 Crofton Centre . Crofton, MD 2 1114 Mizra Nusairee Mo 31. Date filed (Month, Day, Year) . Registrar's Signature OCT 2 5 2007

and manner stated.

6 ☐ Could not be

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature antititle of certifier

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0040519

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**Physician** /Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, cate has been signed by the page 2 should be detached

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or Items 23a or 28a-f show adical Examiner must be notified at

Directo

by Funeral

Completed

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filec Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumatic event, i

Baltimore, Maryland 21215-0036

funeral director,

Certification: To

Examiner

Physician/Medical þ Be Completed

> 3 ☐ Suicide 4 Homicide

> > (Check only

29a. Certifier

6 Could not be determined

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sheldon Goldberg MD 110 Hospital Rd. Suite 310 Prince Frederick MD 20678 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State

To the Hospital or Attending Physician:

filled in by

completely

within 24

		For	State	of Marylan				Mental Hygi	ene	00007
		1 - State Registrar			Cei	rtificate of	Death			36927
Physici	an	Decedent's Name (First, Middle						2. Date of Death Month	Day Year	3. Time of Death
/Medi		Barbara M  4a. Facility Name (If not institution	cAfee	umber)		4h City Town o	Location of Death	Novembe	2r 7,2007	
Examir	ner	Prince Georg					rerly		Prince	
Funeral	-0.3	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	O Diet	hplace (State or Foreign
Director		579-42-1043	1 □ M 2 🔀 F		76 Yrs.	Months Days	Hours Min.	Aug. 12		sh.,DC
and		Usual Residence of Decedent  10a. State 10b, County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Maryli f sho	io	DC			Wash	ington				1 XXYes 2 □ No
r 28a	Director	10e. Street and Number			wabiii	10f, Zip Code		10	g. Citizen of What Co	untry?
th witl 23a o Ist be		#7 49th St.,	SE			2001	9		United S	tates
r dea	Funeral	11. Marital Status	Armed F	cedent Ever in U Forces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36 s afte	by Fi	1 ☐ Never Married 2 ☐ Marri 3 🗷 Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, G Year or			1 ☐ Yes 2 🖾 No	Specify:		Specify: D1	ack
ING 212150036  be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	edk	15. Decedent	's Education		16a. Dece	dent's Usual Occup	ation	- 11	6b. Kind of Business	
215 hin 72 an "na Media	plet	(Specify only highes Elementary/Secondary (0-12)	· i	(1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of wor d)	rking		
27 24 wit 29 with 94 with	Completed				Nurs	se Aid			Private	
Maryland 2121 d 2 should be filed within th and Mental Hygiene. ?? Is marked other than " traumatic event, the Med	Be	17. Father's Name (First, Middle,	,					ne (First, Middle, M	,	
aryland 21215-0036 should be filed within 72 hours after death with the Marylar and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	မ		rray		10h Mailin	a Address /Street	Della	Hawkin	City or Town, State, 2	Zin Cada)
Mar d 2 sho d 2 sho th and 17 is m traums		19a. Informant's Name/Relations  Joanne Morri		<b>7</b> 0	1 2832	Lindes	farn Te	rrace	City or Town, State, 2	zip Code)
ire, Maryls stand 2 should if Health and Mer Item 27 is mark other traumatic		20a. Method of Disposition	son/mre	20b. F	Place of Dispo	Washing sition (Name of matory or other place	ton, Mo	Date 20744	20c. Location - City or	Town, State
O e°± >		1 ∰Burial 2 □Cremation 4 □Donation 5 □ Other (S		n State	•	* *	i	/20/07	Landover	ЬМ
alti mit. partn porta y inju		21. Signature of Funeral Service	Licensee	4					Edwards	
<b>n</b> 285 <b>5</b> 5		Januce	Zawa	ale						Md.20746
		23a. Partl. Enter the disease, or shock, or heart failure. List	complications that only one cause on	t caused the deat each line.	h. Do not ent	er the mode of dyir	ig, such as cardia	or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)		ptic Sh						
/Medical Examiner		rosulang in dodaly		o (or as a conseq		Septice	mio			
N. A	ē	Sequentially list conditions,	U. —	o (or as a conse		peptice	шта			
outed and ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
e exe		resulting in death) Last	Due to	o (or as a conseq	uence of):					
18 / 60, Strate be executed physician and street transit sthe burial-transit	dical		d						-	
± ose	Physician/Me	IF FEMALE:	23c. If ves. o	utcome pf pregna	ancv				23d. Date of de	ivon
Box death cer attendin	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live	e birth 2 ☐ Feta gnant at time of c	al death 3	∃Ectopic pregnancy ∃ Other (specify)	/		Month	Day Year
the c	hysi	9 ☐ Unknown	9□Unk	nown						
res that signed by be deta	by P	Part II. Other significant condition	_	death but not res	ulting in the u	nderlying cause giv	en in Part I.		acco use contribute to	
w require	ted	Respiratory 1	Failure					1 ☐ Ye	s 2 No 3 Pi	robably <b>4</b> Unknown
Hecords, he law requires t e has been signe age 2 should be o	Completed	Acute Renal	Failure					24a. Was ar autops	v prior to	utopsy findings available completion of cause of
		Lung Cancer						perform 1∐ Yes 2	ned? death? No 1 ☐ Yes	2 🔀 No
VITAI siclan: T certificat rector, pë	Be	25. Was case referred to medical examiner?	Hospital:			ot all DOA Oth	ar.	ath (Check only one		
<b>2 £ ± a</b>	1. To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatier 28b. Time o	" 3 DOA	4 LI Nursing F	fome 5 ☐ Reside 28d. Describe ho	nce 6 □Other (Spe w injury occurred	cify)
nding th. :: Afte e fune	tion	1 XNatural 5 ☐ Pendin 2 ☐ Accident investig	y ·	onth, Day Year)	Injury		k? Yes 2 ☐ No			
DIVISION OF in or Attending Phy after death.  Director: After this in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined   Zoe. Flat	ce of injury - At he		eet, factory, office		28f. Location (Str City or Town	eet and Number or R	ural Route Number,
Ital or rs affer ral Distribution	Cert		10							
LIVISION OF VITA  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		Examiner: On the	basis of examina					tuse(s) and manner as ate and place, and due	
o the ithin 2 or the	Med	29b. Signature and title of certifie		anner stated.		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
⊢≯⊬ŏ		1 Lote	MA	MI		200	21,024	ſ	11-8-07	
		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	200	(40-1)		. 0 07	
<u></u> り		Lester Miles	, M.D.	6490 I	Landos	er Rd	Landov	er, Mar	yland 2	0785
Sta		I Lester Miles 31. Date filed (Month, Day, Year) NOV 1	7 2007	Registrar's Signa	ature	mile		ver, Mar		
Regist	rar	MOAT	5 COO!	THE SHOP OF SHIP SHIP SHIP	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEN TIFM 126 per PHYS. C873.11/16/07 VS
State of Maryland / Department of Health and Mental Hygiene 1

36928 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day MARGUERITE A. MILLER 12:44 MPM 2007 November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1526 Deerfield Road Darlington Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 27 F 215-32-2407 Yrs Director 74 4/22/1933 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Directo Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 1547 Deerfield Road 23a Funeral 21034 death USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Tharried Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 TV No ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry th and Mental Hygiene.

7 ie marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Food Service Unknown Public Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Kemp Baker ပ Mildred Steltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Health ar Important: if item 27 te eny injury or other trau once. Blane H. Miller/Husband 1547 Deerfield Road, Darlington, MD 21034 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dublin So. Cemetery 11/8/2007 Darlington, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA and Front the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Scauentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physiclen and I for use as the buriaf-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death Year signed by the at d be detached fo 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Division of Vital the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 NOther (Specify) Residence 1 ☐ Yes 2 No Medical Certification; To 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending Injury after death. investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by filled in by 4 - Homicide To the Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) nones 30. Name and address of person who completed dayse of death (Item 23a) (Type, Print) T SOUTH UNION 1 6 2007 31. Date filed (Month 32. Registrar's Signature State Registrar

Marquerite

State of Maryland / Department of Health and Mental Hygiene 36929 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 1929 10 07 11 Forrest Moreland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Oct.4,1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F 90 Director 705-14-2218 Usual Residence of Decedent 10c, City, Town or Location 10d, Inside City Limits 10a. State 10b. County show r 28a-f show notified at 1 ☐Yes 2 No Director W Mineral Fort Ashby 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it P.O. Box 686 26719 USA Diane Dr. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 No þ 3X Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder's Assistant Railroad permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other I any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Largent ပ Isaac Moreland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Patricia Shoop (daughter)</u> P.O. Box 1166 Augusta, WV 26704 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Levels Cemetery 11/13/07 Levels, W 21. Signature of Funeral Service License 22. Name and Address of Facility McKee Funeral Home Inc. Augusta, WV 26704 P.O. Box 270 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Due to (or as a consequence if): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) November 13,2007 036766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Seton Drive, Cumberland, MD 21502 VIKramadity )oonai 924 32. Registrar's Signature 31. Date filed (Month, Day, Year) 7 2007

Registrar

State

JAC.

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

20

	1 - State Registrar	Certi	ficate of Deal	th	Reg. I	10.2007	36930			
	Decedent's Name (First, Middle, Last)			2	Date of Death	Day Year	3. Time of Death			
ian " cal	NICHOLAS ALEXANDE	R NETE.	FOR	0		31 2001	06:20 M			
ner	4a. Facility Name (If not institution, give street and number)	4	b. City, Town, or Location	on of Death	4	c. County of Deat	h			
	THE JOHNS HOPKINS HOSPITA	4	BALTIMORE	CITY						
		(In yrs. last birthday)	If Under 1 Year   If Under 1 Y	der 24 Hrs. 8 rs Min. J	Date of Birth (Month, Day, Yea July 17, 19	9. Birti 53	hplace (State or Foreign untry) Maryland			
	Usual Residence of Decedent	10a City Town or Locat	ion				and testes on their			
2	10a. State 10b. County	10c. City, Town or Locat	ion				10d. Inside City Limits 1 ☐ Yes 2 🛣No			
Scto	Maryland Howard	Woodbir								
Ö	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Co	untry?			
a	2330 Duvall Road		2179			USA				
l ne	11. Marital Status 12. Was Decedent Armed Forces?	lf Y	s Decedent of Hispanic es, specify Cuban, Mex	Origin? (Speci tican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, White				
Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 N If Yes, Give	lo 1 🗆	Yes 2√Σ No Spec	cify:		Specify: Whi	ite			
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	10. P	de Herrel Oceanie		4.01	100				
ete	15. Decedent's Education (Specify only highest grade completed)	ı (Give kin	it's Usual Occupation and of work done during r NOT use retired)	most of working	160.	Kind of Business/	Industry			
臣	Elementary/Secondary (0-12) College (1-4or 5	+) ""e. DO	Business Owne							
	17. Father's Name (First, Middle, Last)				First, Middle, Maid	ontracting				
Be	Alexander Netefor				nson Murra					
2	19a. Informant's Name/Relationship (Type. Print)	19h Mailing A	Address (Street and Nu			·	Zin Code)			
	Mary Michele Netefor/Wife	1	all Road, Wood			, 0, 10,,,, 0,,,,,,				
	20a. Method of Disposition	20b. Place of Disposition	on (Name of	Dat	te 20c.	Location - City or	Town, State			
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Metropolitan	Cremat on	November	4,	xandria, Vi	iminia			
	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee			2007			пушна			
	21. Organizate of Farietian Service Electrices	A .	lame and Address of Fa ancis J. Coll							
	23a. Part1. Enter the disease, or complications that caused		University B			ing,MD 2090	Approximate			
	shock, or heart failure. List only one cause on each lir	e.		1 40 0414140 011	cophatory arroot,		Interval Between Onset and Death			
	disease or condition a. AE AT	ORENAL SYNA	DROME				2 WEEKS			
		a consequence of):		n 11:00	2110010		W WEARC			
60	Source tally list conditions, b. Due to for as	77S C / ALC	OHOL ZIVER	CIRR	H03/3		7 YEARS			
Examiner	S. uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
xal	resulting in death) Last C Due to (or as	a consequence of):								
<u>a</u>	d									
Medical	- V.									
	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of del	ivery			
icia	in the past 12 months?  1 □ Ves 2 □ No 4 □ Pregnant at		ctopic pregnancy other (specify)			Month	Day Year			
Physician	9 ☐ Unknown 9 ☐ Unknown									
S P	Part II. Other significant conditions contributing to death be	it not resulting in the unde	erlying cause given in Pa	art I.	23e. Did tobacc	o use contribute to	the cause of death?			
Completed by					1 ☐ Yes	2 No 3 □ Pr	robably 4 ☐Unknown			
Set					24a. Was an	24b. Were au	topsy findings available			
E O			.,,,,		autopsy performed 1 Yes 2	? death?	completion of cause of 2 ☐ No			
Be C										
To B	examiner?   Cher: 4   Nursing Home 5   Residence 6   Other (Specify)									
	27. Manner of Death 28a. Date of Inju	y 28b. Time of Injury	28c. Injury at Work?		d. Describe how in					
atio	1 ☑ Natural 5 ☐ Pending (Month, Da) 2 ☐ Accident investigation	reary injury	M 1 ☐ Yes 2	2 □ No						
ifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injute the building, etc.	ry - At home, farm, street	t, factory, office	28	f. Location (Street City or Town, St	and Number or Ru	ural Route Number,			
Ser	3	. ( ) ,		145		4107				
Medical Certification:	29a. Certifier (Check only one)  Certifying Physician: To the best of the basis of and manner start.	examination and/or inves	ccurred at the time, date stigation, in my opinion,	e and place, an death occurred	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. e to the cause(s)			
Me	29b. Signature and title of certifier		29c. License numb	er	29d.	Date signed (Mont	h, Day, Year)			
	DA MEDICAL	DOCTOR	RES-0	000	DOT	OBER 31	2007			
	30. Name and address of person who completed cause of d	-	nt)				21281			
	BERKELEY N. LIMKETKAI, JOHN	IS HOPKINS H	IOSPITAL. 600	NORTH H	VOLFE STRE	ET. SALTIMO	ORE MARYLAND			

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Registrar's Signature

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.						
	4	State of Maryland / Dep	estificate of Dooth	, 0		
		Registrar Amended #4b per Phys FCHD C6	entificate of Death 11/6	5/07 Reg. N 2. Date of Death	2007 3.6.2.3.1	
Physician	n	GARY WAYNE NEWCOMER		Oct. 24, 2007 0900 am		
/Medica Examine		4a. Facility Name (If not institution, give street and number) 109 S. Bentz Apt. #4	4b. City, Town, or Location of Death Frederick, Mary	4	c. County of Death Frederick	
Funeral Director		5. Social Security Number  6. Sex 1 Number 7. Age (In yrs. last birthda) 1 Number 42 Yrs.	Months Days Hours Min /Month Day, Yea		9. Birthplace (State or Foreign Maryland	
70		Usual Residence of Decedent	ocation		10d. Inside City Limits	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	_	Md. Frederick Frederick 1\(\mathbb{L}\)Yes 2\(\Dag{\text{N}}\)				
	5	10e. Street and Number 109 S. Bentz Apt.#4	10f. Zip Code 21701	10g. C	Citizen of What Country?	
ems 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
ours afte ral", or it Examin	ਨ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates:	1 ☐ Yes 2 【XNo Specify:		Specify: White	
72 ho	erec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gir.	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	16b.	Kind of Business/Industry	
within iene. than the Me			r Condition Tech/Br		Construction	
lid be filed fental Hyg rked othe lic event,	to be completed	17. Father's Name (First, Middle, Last) Russell Jacob Newcomer, Jr.	18. Mother's Nam Lucy V •	e (First, Middle, Maide Talton	en Surname)	
d 2 shou th and M 7 is mar traumat	-	, , , ,	lling Address (Street and Number or Run 530 Foxhall Ct. Fre			
s 1 an if Heal item 2 other	-	20a. Method of Disposition 20b. Place of Dis			Location - City or Town, State	
it. Page intment c intant: If injury or		4 Donation 5 Other (Specify) Smithsb	urg Crematory 10/2		ithsburg, Md.	
Depa Impo any ii		Low Etterfeet	ROBERT E. DAILEY & 1201 NORTH MARKET S	ST. FREDEI		
		23a. Part 1. En er the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line.  Approximate Interval Between Onset and Death				
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	of the live		y earl	
Examiner		Due to (or as a consequence of):				
D .=	le l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
oe executed cian and ourial-transit	Due to (or as a consequence of): cause. Enter Underlying Cause (Disease of Higher) that initiated events resulting in death) Last  Due to (or as a consequence of):  Co.  Due to (or as a consequence of):					
e be er						
rtificate brug physiclast the bu	Jedi	E FEMALE.				
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
res that the signed by be detacted.	2	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to the cause of death?	
w require been sig should b	ered					
hysician: this certifice al director, p	Completed			24a. Was an autopsy performed? 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No	
	g C	25. Was case referred to medical examiner?  Hospital:	Othor	th (Check only one)	_	
	01:10	1  Yes 2 No Positian 1  Inpatient 2  □ ER/Outpati 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how in	6 □Other (Specify) jury occurred	
To the Hospital or Attendi within 24 hours after death.  To the Funeral Director; A completely filled in by the fi	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
Hospital 4 hours a Funeral I ely filled		29a. Certifier  (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)				
within 2. To the I complet	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month, Day, Year)	
F S F Ö		· Sley bhe nd	MDD31058	1	0-26-2007	
		30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Gene F. Ashe, MD , 10200 Copperminek Rd. Woodsboro, Md. 21798				
State Registra		31. Date filed (Month, Day, Year)  32. Register's Signature	Sporte			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician**  $p^{M}$ 1, 2007 November 1:30 /Medical Claudia P. Pierie 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) 13207 Autumn Drive Silver Spring 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 □ F 426-16-0965 86 Director Nov. 19, 1920 Mississippi Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 Tx Yes 2 □ No Director Mississippi Panola Sardis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 104 Franklin Street 38666 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ 1 any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White þ Specify: 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Franklin Patton Lillian Foster Jackson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Kalcounos/ Daughter 13207 Autumn Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 5, 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2007 Rose Hill Cemetery Sardis, Mississippi 21. Signature of Funeral Service Licer 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Small Cell Lung Cancer 3 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No Mar Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) aughter's 1 ☐ Yes 2X No 1 | Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Residence Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie d54378 November 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2730 University Blvd, West, #400, Wheaton, MD 20902 Cheryl Aylesworth, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2007

Box 68760,

P.O. I

Records,

Division or Vital

egistrar's Signature

licha	el N. Porte	1	State of Maryland / Department of 1- For State Certificate of		_	g. No. 200	7 3693
	Physicia	_	Registrar  1. Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
Vledi	cal Exami		Michael Nicholas Porter		Month October 28		0933 hrs
			4a. Facility Name (if not institution, give street and number)  10575 Tralee Terrace	o. City, Town, or Location of Death  Damascus		4c. County of Death Montgomery	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_	h(MM/DD/YYYY) 9. Birt Foreig	
	Director		099-74-5170 1x M 2 F 20 Yrs.	Months Days Hours Min			intry) NY
	any	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
	. ₹	_	MD. Montgomery Damaso	us			1 X Yes 2 No
3	with the Maryland ms 23a or 28a-f show be notified at once.	Director	10e. Street and Number	10f. Zip Code	10	g, Citizen of What Cour	try?
3	the Na or		10575 Tralee Terrace	20872		US	
11000		Funeral	1 X Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origin? (Ses, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc.	can Indian, Black,
	ter dez ", or i		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X No specify:		Specify: B1a	ick
	ours af ntural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	's Usual Occupation (Give kind of ost of working life. DO NOT use ret		16b. Kind of Business/I	ndustry
	5-0036 ted within 72 hours after deatt Hygiene. other than "natural", or ite the Medical Examiner must	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	· ·	1160)		
	within giene.	E O	1 2 L 17. Father's Name (First, Middle, Last)	aborer 18. Mother's Name	e (First, Middle, N	Meadow Far	ms Nursery
:	21215-0036 Muld be filed within 7 Mental Hygiene. marked other than ic event, the <u>Medica</u>	Be C	Edgar Michael Porter	Rebec	ca Sue H	orst	
	ould be fill d Mental I is marked tic event,	은		Address (Street and Number or	Rural Route Num	nber, City or Town, State	, Zip Code)
	y, MD 2121 and 2 should be fi tealth and Mental I tem 27 is marked traumatic event,			11th St. Wilm:	ington, Date	DE 19801 20c. Location - City or	Town. State
	nore, MD ages I and 2 sh nt of Health an nt: If item 27 i		1 Burial 2 X Cremation 3 Removal from State crematory or oth	er place)			
	Baltimore, permit. Pages I ar Department of Her Important: If ite		4 Donation 5 Other Specify: Chesapeak 21. Signifulty of Funeral Service Licensee 22. N	e Crematory 11, ame and Address of Facility Mc(	/07/07	Beltsville	. MD
	Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is minjury or other traumatic.		Undre' Ohomson 74	00 Georgia Ave.	, NW Wa	neral Servi shington, D	ce, inc. C 20012
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
	Medical xaminer		Immediate Cause (Final disease a. Methadone intoxication				Death
			or condition resulting in death)  Due to (or as a consequence of):  b.				
		ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
B		Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			-	<del> </del>
P	60,  the be executed hysician and e burial - transit	a E	d.				
	60, ate be ex hysician e burial	/edical	X UNPENDED AMENDED , 11/20/07 TT		23d. Date of deliver		
	1876 tificat ing phy as the	M/m	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fe	tal death 3 Ectopic pregr	nancy		y Day Year
	Division of Vital Records, P.O. Box 687) and or Attending Physician: The law requires that the death certificate and Director: After this certificate has been signed by the attending pled in by the funeral director, page 2 should be detached for use as the	Physician/	1 Yes 2 No 9 Unknown g Unknown	her (Specify)		1	
	O. B trhe de by the ached 1	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
	, P.( res tha signed be det	d by			1 Ye	s 2 No 3 Pro	bably 4 🗸 Unknown
	v requi	Completed			24a. Was autor	psy prior to	utopsy findings available completion of cause of
	RecC The lay cate ha	E O				ormed? death? 2 No 1 ✓ Y	es 2 No
	tal F tian: certifi ector, ]	Be C	25. Was case referred to medical examiner? Hospital: 4 Inspital: 4	26.Place of Death (Chec			
	f Vid Physic er this ral din	2	1 V Yes 2 No riospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of I	o	ing Home 5	Residence 6 Othe	er: Scene
	nding th r: Aft	i ii	1 Natural 5 Pending Find 10/28/2007 Fnd 9:2	1 Yes 2 TV No	unk	, .	
	ivisic or Atte after dea Directo	fical	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre				ural Route Number, City
	Divoletal of hours af uneral D	Certification:	4 Homicide determined (Specify) found at home		10575 Tr	<u>alee Terrace l</u>	
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occu (Check only one) ✓ Medical Examiner:On the basis of examination and/or investiga	rred at the time, date and place, ar tion, in my opinion, death occurred	nd due to the cau I at the time, date	se(s) and manner as sta and place, and due to t	ted. he cause(s)
	To To t	Med	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M	
			Pota Aron 12-Pollice	O.C.M.E.		October 29, 200	07
			30. Name and address of person who completed cause of death (Item 23a)	444 Danis Otras I D W	ND 0400	11	
			Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Mogth, Day, Year) 32. Sejistrar's Signature 32.	111 Penn Street, Baltimo	JIE, WID 272€	ا ر 	
	Regi	itate strar	NEEV / / / WILL POR / Po KANN				

		•	State of Maryland 1tens 27,28a-f pe	d / Department of H er meenilcate / O	lealth and Me <b>6/07dhb</b>	ental Hygi Re	ene g. No. 200	7 36935
	Dhysisi		1. Decedent's Name (First, Middle, Last)	-	2	2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Vernon Poole			11	04 200	7 6 10 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		Location of Death	–	4c. County of Dea	
.tet	*	A	Carroll Hospital Center		inster,	MD	Carro	
В	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	/ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		217-10-1000 91	115.	A	pril 24	,1916 Ke	ntucky
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City	, Town or Location				10d. Inside City Limits
	n the Marylan r 28a-f show r notified at	ō						1 Yes 2 □ No
	the N 28a-	Director	Maryland   Carroll   Mt.  10e. Street and Number	Airy		10	g. Citizen of What C	ountry?
	with ga or t be				1771			
	leath ns 23 mus	Funeral	713 Midway Avenue  11. Marital Status 12. Was Decedent Ever in U.		1771 ispanic Origin? (Speci	ify Yes or No-	USA 14. Race - Am	erican Indian,
· O	r iter	Ξ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No			ican, etc.)	Black, Wh	ite, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	þ	3 ∰Widowed 4 □ Divorced If Yes, Give Year or Dates: WW	II 1□Yes 2x No	Specify:		Specify:	White
Ō	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup			6b. Kind of Business	s/Industry
21	thin an "I	ple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired			TT 1	w.c
2	filed wi Hygier ther th	S	2	Salesman			Hardware	mrg.
2	0 = 0 5	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (	First, Middle, M	aiden Surname)	
<u>X</u>	should be and Mental marked o	2	Edward K. Poole		Effie		Jones	
altimore, Maryland	au si		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street				* *
e o	l and lealth m 27 her ti		Lana Harper/Daughter	12351 Sherwo			Oc. Location - City of	
0	00		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	lace of Disposition (Name of emetery, crematory or other plac	Noveml	·	oc. Location - City o	Town, State
=======================================	t. Pa tmen tant:			uffer Cremator			rederick,	
g	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Landsee	22. Name and Addres				
	ED = 60		To cary a control		eville Blv			
М			23a. Part Pater the disease, or complications that caused the death shock, or hear failure. List only one cause on each line.	1. Do not enter the mode of dyin	ig, such as cardiac or	respiratory arre	St,	Approximate Interval Between Onset and Death
	Physician		Immediate Fause (Final disease or condition resulting in death)  a. Sepsis					24 hr
	/Medical Examiner		Due to (or as a consequ	*				40.1
	= 72.5	<u>.</u>	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence)		- //	/		-13-NP
	ted 1sit	Examiner	Cause (Disease or injury	derive oij.	ON MODROUGO BY VIEDIC	MANNER		
	icate be executed physician and the burial-transit	xar	that initiated events resulting in death) Last c	uence of):	A KIEDIC	MENO		
8760	be e sician burit	E E			NOROVED BY WILL			
89	ficate physics the	edical	u	adri)	W W			
Box	death certific e attending p d for use as	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregna	incy CER.			23d. Date of d	elivery
ň	death a atte	icia	in the past 12 months?  1 Vos. 2 No.  4 Pregnant at time of d		<b>'</b>		Month	Day Year
Ö	t the	Physician/Me	9 ☐ Unknown					<u> </u>
ď.	The law requires that the de tre has been signed by the sage 2 should be detached	by P	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Š	quire an sig uld b	pe	hip tracture			1 ☐ Ye	s 2[ <b>X</b> No 3∏ I	Probably 4 Unknown
ပ္တ	aw re s bee	Completed				24a. Was an		autopsy findings available
ř	The late has age 3	E O				autopsy perform 1⊟ Yes 2	ed? death? No 1 □ Ye	
Vital Records,		BeC	25. Was case referred to medical		26. Place of Death			
>	Physiclan: r this certific ral director,	To B	examiner? 1X Yes 2 No Hospital: 1X Inpatient 2 □	ER/Outpatient 3 DOA Oth	er: 4 □ Nursing Hom	e 5 🗆 Resider	nce 6 □Other (Sp	ecity)
Division or	ng Ph ter th neral		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injur Wor	y at 28 k?	3d. Describe ho	w injury occurred	
0	ath. or: Af	atio	Accident investigation 11/02/2007	Unknown 10		ubject	fell.	
Š	r Attu	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At ho building, etc. (Specification of the state	ome, farm, street, factory, office		City or Town.	State)	Rural Route Number,
	ital or rs aft ral Di	Cer	Nursing T  29a. Certifier 1 Certifying Physician: To the best of my kno			713 Mid	way Ave.,	Mt Airy,MD
	Hosp 4 hou Funel ely fil	cal	(Check only 2 Medical Examiner: On the basis of examina					
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. Licens	e number	200	d. Date signed (Mo	nth Day Year)
ı	<b>1</b> × 1 × 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	_	29b. Signature and title of certainer	7	47070	23	d. Date signed (Mo	
)	\		vnereu 11/11/4ct	rele bol	1414		11/04	12007
	VX		30. Name and address of person who completed cause of death (Item		ale mana	d war	01779	3
110	,	to	Theresa M Michele 3707 31. Date filed (Month, Day, Year) 32. Registrar's Signa		blenwoo	a, MD	2173	0
	Sta Registr							
DHI	MH 17 Rev 1/2		NOV 0 6 2007	# Sperker				
		,		ORIGINAL				

Division or Vital Records, P.O. Box 68760

/Medical Examiner Examine physician veician/Medical After

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

**Funeral** 

Director

r 28a-f show notified at

o e

ral", or items 23a Examiner must b

'natural", or

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If Item 27 Is marked other than amy injury or other traumatic event, the once.

**Physician** 

the !

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome pf pregnand  1 ☐ Live birth 2 ☐ Fetal d  4 ☐ Pregnant at time of dea  9 ☐ Unknown	eath 3□Ectopic	c pregnancy (specify)		23d. Date of delivery Month Day Ye	ear
Part II. Other significant conditions col Cardiac decreased eje					cco use contribute to the cause of de : 2  No 3  Probably 4  Ur	
Insulin-Dependent Dia	abetes Mellitus, Ar	nemia of Ch	nronic Disease	24a. Was an autopsy performa 1  Yes 2 □	ed? death?	vailable use of
25. Was case referred to medical			26. Place of De	ath (Check only one)	)	
	Hospital: 1 🛣 Inpatient 2 🗆 EF	R/Outpatient 3□	DOA Other: 4 Nursing I	forme 5 ☐ Residen	ice 6 Other (Specify)	
27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation		8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
3☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	e, farm, street, fac	etory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Numb State)	oer,
29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my knowl iner: On the basis of examination and manner stated.	edge, death occur n and/or investiga	red at the time, date and plac tion, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)	)
29b. Signature and title of certifier			29c. License number	290	d. Date signed (Month, Day, Year)	
			D43330		October 31, 2007	

State

Registrar

Barry Greene, MD 31. Date filed (Month Day, Year) 9707 Medical Center Drive, #200, Rockville, MD 20852

₩gistrar's Signature

2007

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 5:46 P October 30 Bruce E Randolph 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Frederick Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day, Year) July 19, 1957 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days 219-68-9636 Hours 50 MA. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ZYes 2 □ No MO. FREDERICK FREDERICK 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6970 ROOKS COURT APT 105 21703 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 1 No Specify: Specify: ELACK 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) UNITED DISPOSAL College (1-4or 5+) TRASH COLLECTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ERVIN RANDOLPH FRANCES CURTIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1254 DANIELLE DR. FREDERICA MO 21703 JENKINS (SIS) BARBARA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) NOV 8, 2001 FREDERICK MD. FAIRVIEW Ctm. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FON. ITOM C 110 WEST SOUTH ST PREDERICE MODITOR Sam 23a. Part1. Enter the efsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenia Due to (or as a cons nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 1□ Yes 2 No 26. Place of Death Check onl one Hospital:

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

þ

Completed

Be

೨

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun

Saltimore, Maryland 21215-0036

burial-tran Physician/Medical the Completed Certification: To after death filled in by

law requires that the death certificate be executed

Hospital or Attending Physician:

To the

24 hours a

within 24 hor To the Fune completely fi

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D0035106 29d. Date signed (Month, Day, Year) OCT 31, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Idea Nam MD

400 WEST 744 St FREDERICA Md 21701 Myung Hee Nam
31. Date filed (Month, Day, Year)

State Registrar

Medical

NOV 0 6 2007



### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Marv Jane Rice November 8, 2007 5:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood of Williamsport Williamsport Washington 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Yrs 215-14-6226 Director 86 June 19, 1921 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1 ☐ Yes 2 → No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11036 Roessner Ave. Funeral 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimo, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even John McFadden Beckman Esther Heller ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai Frances J. Rice/Daughter 11036 Roessner Ave., Hagerstown, MD 21740 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 11/14/2007 | Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complicators that caused the death. Dashock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** HAONIC /Medical Due to (or as a consequence of): **Examiner** YPENTO-100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ MaciRe( 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No performe 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

or Attending Physician: The law requires that the death certificate be executed

s after dec. filled in by To the Hospital o within 24 hours aft To the Funeral Di completely filled in

4 Homicide

29a, Certifier (Check only one)

29b. Signat

10	
Sta	te
Registr	ar

DHMH 17 Rev 1/2001

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

death (Item 23a) (Type

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

	State Registrar						Ce	ertificate	e of L	Death			Reg.	No.	201	07	3	69
	1. Decedent's Name	e (First, Midd		L				Smith	h			2. Date of I Month		Day	Yea		3. Time o	Death
2	4a. Facility Name (If	f not institutio			mber)					r Location		Novemb	er		2007 nty of De		10:45	A <sup>h</sup>
77	345 Wind				mber)				erst		or Bodui				shing		n	
	5. Social Security N		6. Sex		7. Age (I	n yrs. last	,			If Under	24 Hrs. Min.	8. Date of E	Birth Day, Ye		9. B		ace (State	or Forei
	216-30-29 Usual Residence of		1 L M	2 <b>X</b> ) F		80	Yrs.					Sept.						
ŀ	10a. State	10b. County	/		10	Oc. City, To	own or L	ocation			-					10	d. Inside C	ity Limi
	MD	Washi	ington	1		Hag	gersi	town									1 ☐ Yes	2 <b>K</b> ) N
	10e. Street and Nur							10f. Zip					10g.	Citizen o	of What	Count	ry?	
	345 Wind	ling Oa			edent Eve	r in II S	13	Was Dacad		ienanic O	iain? (Sn	ecify Yes or f	No-		S . A		n Indian.	
	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ied 217 Mar	rried	Armed Fo 1 ☐ Yes	orces? 2 ☑ No	1 11 0.5.	13.	If Yes, spec	cify Cuba	an, Mexica	n, Puerto	Rican, etc.)	NO.		Black, Wi			
•	3 Widowed		1	If Yes, Gi Year or D	ve			1 ☐ Yes 2	2 <b>∏</b> No	Specify	:			Spe	cify:	Vhi	te	
1	(Spec	15. Deceder				1	(Giv	edent's Usua e kind of wor	rk done d	durina mo	st of work	ring	16	o. Kind of	f Busines	ss/Indu	ustry	
-	Elementary/Seco	ndary (0-12)		College (	1-4or 5+)		_	DO NOT us	se retired	1)			1	ewe1	rv			
	17. Father's Name (	(First, Middle	, Last)				<u> </u>	aver		18. Moth	er's Name	e (First, Mida						
	John B.	Landi	.s							Biro	ly Ma	y Pheb	us					
1	19a. Informant's Na	ame/Relation:	ship (Type.	Print)		1	19b. Mai	ling Address	(Street	and Numb	er or Rur	ral Route Nun	nber, C	ity or Tov	wn, State	9, Zip (	Code)	
-	Earl R.  20a. Method of Disp		Husba	nd		20h Place		Windi		0ak I		e, Hage			MD on - City		1740	
	1∭ Burial 2 [	☐ Cremation		oval from	State	cem	etery, cr	ematorý or o	ther plac	í i					-		,	
-	4 ☐ Donation 21. Signature of Fu					Nest		en Cen				5/2007			stov			
- 1							2	22. Name an	nd Addres	ss of Facil	ity Re	est Hav	ren	Fune	eral	Ch.	apel	
	23a. Part1. Enter the shock, or hea	he disease, d int failure. Lis	Su	no	caused the	e death. [	1 Do not ei	nter the mode	enns le of dyin	y1var ng, such a	nia A s cardiac	or respiratory	lage	rsto		MD	217 Approxima Interval Be	te tween
	Immediate Cause ( disease or condition resulting in death)	(Final n	Su	that cause on e	Yasta	/ / .	Do not ei	.601 Pe	enns le of dyin	y1var ng, such a	nia A s cardiac	ve., F	lage	rsto		MD	217 Approxima	te tween Death
	Immediate Cause (	nditions,	or complication only one of	Me Due to	Yas Ya (or as a co	atic	Do not en	.601 Pe	enns le of dyin	y1var ng, such a	nia A s cardiac	or respiratory	lage	rsto		MD	217 Approxima Interval Be Onset and	te tween Death
	Immediate Cause (disease or condition resulting in death)  Sequentially list conditions to the cause. Enter Unde Cause (Disease or that initiated events	regularity of the pregnant months?	a. b c d	That de one one one one one one one one one on	(or as a co	e fic onsequen	Do not ellected of the control of th	.601 Pe	enns le of dyin	ylvai ng, such a:	nia A s cardiac	or respiratory	lage	ersto		MD	217 Approxima Interval Be Onset and 3 M	te tween Death
	Immediate Cause (disease or condition resulting in death)  Sequentially list confidence in the cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12	nditions, and distributing injury start t pregnant months?	a. b c d 23c.	Due to  If yes, out   Up to	(or as a co	onsequen  onsequen  pregnancy  Fetal de  ne of death	Do not eller control c	nter the mode	enns le of dyin le nc	ylvar	nia A	or respiratory	arrest	ersto	Date of a	MD	217 Approxima Interval Be Onset and 3 M	te tween Death
	Immediate Cause (disease or condition resulting in death)  Sequentially list contrainty list contrainty list contrainty list contrainty list contrainty list contrainty list contrainty list cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 Yes 26 9 Unknown	nditions, and distributing injury start t pregnant months?	a. b c d 23c.	Due to  If yes, out   Up to	(or as a co	onsequen  onsequen  pregnancy  Fetal de  ne of death	Do not eller control c	nter the mode	enns le of dyin le nc	ylvar	nia A	ave., For respiratory	arrest	ersto	Date of common Month	MD	217 Approxima Interval Be Onset and 3 MM	Year
	Immediate Cause (disease or condition resulting in death)  Sequentially list contrainty list contrainty list contrainty list contrainty list contrainty list contrainty list contrainty list cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 Yes 26 9 Unknown	nditions, and distributing injury start t pregnant months?	a. b c d 23c.	Due to  If yes, out   Up to	(or as a co	onsequen  onsequen  pregnancy  Fetal de  ne of death	Do not eller control c	nter the mode	enns le of dyin le nc	ylvar	nia A	23e. Di	arrest  d tobac  Yes as an topsy	23d.	Date of of Month	MD  deliver  representation of the probability of t	217 Approxima Interval Be Onset and 3 MM	te te the
	Immediate Cause (disease or condition resulting in death)  Sequentially list contract the cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, mediaterying injury sast	a.  c d 23c.	Due to  Due to  Due to  Due to	(or as a co	onsequen  onsequen  pregnancy  Fetal de  ne of death	Do not eller control c	nter the mode	enns le of dyin  ensemble of d	ylvar ng, such a: er-	nia Assardiac	23e. Di	d tobac	23d.	Date of of Month	MD  deliver  representation of the probability of t	217 Approximal Interval Be Onset and 3 MM	te te the
	Immediate Cause (disease or condition resulting in death)  Sequentially list contract of the cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, and distributions of the conditions of	a.  c 23c.	Due to  If yes, out 1   Live   4   Preg   9   Unknowting to do	(or as a control of the control of t	onsequen  onsequen  pregnancy  Fetal de ne of death	Do not eller control of the control	meter the model	enns le of dyin  regnancy pecify)  ause give	ylvar ng, such a: er- 26. Placer: 4 \( \text{N} \)	nia Assardiac	23e. Di 1[ 24a. Wi 24a. Wi 24b. (Check onlo	d tobac	23d. 23d. 24d? 1No	Date of o Month  contribute o 3   tb. Were prior t death 1  Y  Other (S)	MD  deliver  E  a to the  Proba  autopoto com  ??	217 Approximal Interval Be Onset and 3 Multiple State of	te te the
	Immediate Cause (disease or condition resulting in death)  Sequentially list control of the cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1   Yes 25 9   Unknown  Part II. Other signification of the cause of the cause (Disease or that initiated events that initiated events resulting in death) L  25b. Was case referenceminer?  1   Yes 25   Yes 26   Yes 26   Yes 26   Yes 26   Yes 26   Yes 26   Yes 26   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 27   Yes 28	nditions, mediate ritying injury stast t pregnant months?	a.  c 23c.	Due to  If yes, ou  Ultive to  Pregged unknowning to de	(or as a control of the control of t	onsequen  onsequen  pregnancy  Fetal de ne of death	Do not eller control c	meter the model	regnancy pecify) ause giv	ylvar ng, such a: er- 26. Placer: 4 \( \text{N} \)	nia Asserdiace Assertiace 3e. Di 1[ 24a. Wi au pe	d tobac	23d. 23d. 24d? 1No	Date of o Month  contribute o 3   tb. Were prior t death 1  Y  Other (S)	MD  deliver  E  a to the  Proba  autopoto com  ??	217 Approximal Interval Be Onset and 3 Multiple State of	te te the	
	Immediate Cause (disease or condition resulting in death)  Sequentially list confiant, leading to fit cause. Enter Under Cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1	nditions, and districting injury state to medicate the medicate to medicate the months?	a.  c  23c.  lions contributing digation	Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	(or as a column of the column	onsequen  onsequen  pregnancy  Fetal de ne of death  not resultin  2 □ ER.  /ear)  28	Do not end of the control of the con	Dectopic production of 2	enns le of dyin  le of dyin  regnancy  regnancy  ause giv	ylvar ng, such a:  er  26. Place er: 4 □ N  x at  x at	nia Asserdiace Assertiace 3e. Di 1[ 24a. Wi 24a. Wi 24b. (Check onlo	d tobac  Yes  as an topsy rformers  y one)  (Strees	23d. 23d. 24d? No 24d? No e 6 00 injury occ	Date of common to the contribute of a large of the contribute of t	MD  deliver  e to the  Proba  autopoto com  ?es  ipecify,	217 Approximal Interval Be Onset and 3 MM	Year  Year  Unknov  availata auuse o	
	Immediate Cause (disease or condition resulting in death)  Sequentially list contract of the cause (Disease or that initiated events resulting in death) L  IF FEMALE: 23b. Was decedent in the past 12 1 Yes 28 9 Unknown  Part II. Other significations of the cause (Disease or that initiated events resulting in death) L  25b. Was case referexaminer? 1 Yes 28 29 Unknown  25c. Was case referexaminer? 27c. Manner of Death Natural 2 Accident 3 Suicide	Inditions, medical relations of the pregnant months?  No red to medical relations of the predical  a.  c  c  23c.  lions contrib	Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to  Due to	(or as a column of the column	onsequen  onsequen  pregnancy  Fetal de ne of death  not resultin  2 □ ER.  (ear) 28  - At home Specify)  my knowle tamination	1   1   1   1   1   1   1   1   1   1	Determinent and Door of 2 M street, factory	regnancy ecify) ause given ause given at the tire	ylvar ng, such a: er 26. Place: 4 \( \text{N} \) yat k? Yes 2 \( \text{Tme, date a} \)	inia Assignment of Assignment	23e. Did 1/2 24a. Wing per control of the Check only control of the Ch	d tobacc  Yes as an topsy rformer former as y one) (Strees how	23d. 23d. 24d? No 24 d? No e 6 () injury occ stand Nu state)	Date of community of the contribute of the contr	MD  deliver  a to the  Proba  autopto com  ?  es 2  Expecify,  Rural	217 Approximal Interval Be Onset and 3 MM  Y Day  e cause of ably 4 pay findings appletion of 6 2 No  Route Nurrelated.	Year  Year  Unknov  availat ause o	

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 9 2007

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Elmer Smith 1:25P 10 2007 November 4b. City, Town, or Location of Death 4c. County of Death New Windsor Carroll If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 24, 1 6. Sex 7. Age (In yrs. last birthday) Days 1[**X**M 2□ F 82 1925 Maryland 10c. City, Town or Location 10b. County New Windsor Carroll

filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036

**Funeral** 

Director

r 28a-f show notified at

a or

**Physician** /Medical Examiner

The law requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, the attending phase as t þ has

certificate To the Hospital or Attending Physician: After

r than "natural", or items 23a the Medical Examiner must b 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental Dennis B. Smith 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If item 27 is any injury or other trau once. 3320 Mill Dale Lane Edna S. McNemar/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winters Cemetery 21. Sign fun of Funeral Service (attarine ). 310 Church St. Immediate Cause (Final disease or condition disease or condition resulting in death) Due to (or as a consequence f) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4 □ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9∏Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ estive Completed 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

of person who completed cause of death (Item 23a) (Type, Print)

S. MO

32. Registrar's Signature

**Physician** /Medical 4a. Facility Name (If not institution, give street and number) Examiner 524 Smith Rd. 5. Social Security Number Birthplace (State or Foreign Country) 219-14-8221 Usual Residence of Decedent 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 U.S.A. 524 Smith Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify. Specify. þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) farmer 11 dairy 18. Mother's Name (First, Middle, Maiden Surname) Edna L. Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Windsor, MD 21776 20c. Location - City or Town, State 11/14/2007 | nr. New Windsor, MD 22. Name and Address of Facility Hartzler Funeral Home New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death years 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

Helbert

12164

Man hy ste Rd Manchestor MM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 7 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** STRATTON OCTOBER 28, 2007 3:59A DAVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Months 1**X** M 2□ F 48 September 26,1959 Wash., Director 577 88 6570 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10h. County r 28a-f show notified at Yes 2 No Funeral Director Suitland Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ral", or items 23a or Examiner must be USA 20746 5212 Morris Avenue #105 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than "natu imatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Stratton Elsie Hoaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7705 Topton Street New Carrollton, MD Robert Stratton/brother Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11-2-07 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory Alexandria, VA 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 21. Signature of Funeral Service Ligensee 23a. Pyr1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. SUITLAND, MD 20746 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Syli Comia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Decubita Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit 1) 14belis Due to (or as a consequence of): by Physician/Medical IF FFMALE: 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 2 Fetal death 1 ☐ Live birth Year Month Day in the past 12 months? 4□Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? quadro Pleilla 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform gaslerostem 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA P After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

KHOSROW DAVACHI, M.D.

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ORIGINAL

7801 OLD BRANCH AVE. #409

CLINTON, MD 20735

Division or Vital Records, P.O. Box 68760,

State Registrar

nonth, Day, Year) NOV 02 31. Date filed (Month, Day, 2007

an

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

111 GZ

DYIYC

29d. Date signed (Month, Day, Year)

Germantern or D SCE

			State of Maryland / Dep		lealth and	Mental Hy	,	gible.	3601.3
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  CARL A STEELE JR			2. Date of De Month	Day 23	υ υ <i>τ</i> 07	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number)  Mandrin Hospice House  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Harwoo	_	2 Date of Rin	Ann	nty of Death	
	Funeral Director		578-48-1474	Months Days	Hours Min		y, Year)	Mary	lace (State or Foreign htry) land
	the Marylan 28a-f show notified at	Director	Maryland Prince George's Suitlar  10e. Street and Number				10g. Citizen		0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	h with		5905 Delta Lane	20746	5			ISA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	B. Was Decedent of H If Yes, specify Cub		Specify Yes or No rto Rican, etc.)	E	Race - Americ Black, White, cify: Wh	
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur the Medical I	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occup ve kind of work done . DO NOT use retire rinter	pation during most of wo d)	orking		Business/In	·
þ	e filed al Hyg other vent, i	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle	•		
ylar	Menta Menta arked atic ev	To E	Carl A. Steele, Sr.			anor May			-
, Mar	and 2 sho ealth and m 27 is ma		Vicki L. Steele/ Daughter 5605	Glenwood		c., Alexa	andria,	VA 22	2315
timore	Pages 1 Iment of H tant: If Iter jury or oth		1 MaBurial 2 □ Cremation 3 □ Removal from State Cedar H	position (Name of rematory or other pla i11 Cemete	ery  10/2		Suit1a	-	)
Bal	permit Depar Impor any in		fletret V'Elel-	22. Name and Address 2973 So1c	omons Isl		Edgewa		ID 21037
A.	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	0	log, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
,092	iicate be executed physician and s the burial-transit	ja	that initiated events c						
89	rtifical ng phy as th	/ledi	IF FEMALE.						
P.O. Box	the death certificate to the attending physic ched for use as the to	Physician/Medic		B ⊟Ectopic pregnanc i ⊟ Other <i>(specify)</i> _	ey		23d.	Date of delive Month	ery Day Year
	w requires that the deben signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did t			he cause of death?
Division or Vital Records,	The lay	Completed				24a. Was auto perfo 1∐ Yes			opsy findings available impletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?			eath (Check only	-	M	ANDRIN
or	Physi this c	To	1	eur all poy		Home 5 ☐ Resi		- ' '	y itospice
ion	ath. rr: After re funer	ation	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	/ Wo	rk? ]Yes 2∐No	Zud. Describe	now injury oc	curred	t+ou)
Divis	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, so building, etc. (Specify)	street, factory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Run	al Route Number,
	the Hosp hin 24 hou the Funei upletely fil	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.		opinion, death oc		, date and pla	ce, and due t	o the cause(s)
	17-00 5 # 5 8	2	29b. Signature and title of certifier with the contract with the c	D	214	38	Oct	7.3	7.007
	Sta	ate.	30. Name and address of person who completed cause of death (Item 23a) (Typ  MICH AEL (The Property of the Completed Cause of death (Item 23a) (Typ  31. Date filed (Month, Day, Year)  32. Registrar's Signature	DEFON	ISE H	16 HWA	MAM	NAPOL	es MD rutol
DH	Registi IMH 17 Rev 1/2	rar	OCT 2 5 2007	forte					

			1 - For State Registrar	tate of Marylar		irtment of F		-	giene Reg. No. 200	7 36	5944
	Physici		Decedent's Name (First, Middle, Last)     Dionnte Marcque	eis Swins	ion			2. Date of Dea Month Novem	ath Day	Yeer	me of Death
2	/Medio Examir		4a. Facility Name (If not institution, give street		7011	4b. City, Town, o	r Location of Death		4c. County of		
			Oliver Shop Road 5. Social Security Number 6. Sex	at Tawnya 7. Age (In yrs.	cres	LaPla If Under 1 Year	ta If Under 24 Hrs.	8. Date of Birt	Ch	arles	
Н	Funeral Director			2□F 7. Age (III y/s.	15 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 28,1992	9. Birthplace (St. Country) Md.	ate or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation					de City Limits
	Maryli of sho	tor	Md. Charles		aPlata						Yes 2 No
	or 28a	Director	10e. Street and Number		<u> </u>	10f. Zip Code			10g. Citizen of Wh	at Country?	
	e 23a	erai I	430 Nanjemoy Dri		6 40 1		546		United		
ور	after de or Itam riner	Funerai	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo		Vas Decedent of H Yes, specify Cuba		Rican, etc.)	Black,	- American India White, etc.	ın,
1215-0036	be filed within 72 hours after death with the Maryland all Hygiene.  do they than "natural", or farme 23e or 28e-f show other than "natural", or farme 25e or 28e-f show event, the Madical Evantina must be notified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		Yes 212 No	Specity:			Black	
-5	n "nat	Completed	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	during most of wor.	king	16b. Kind of Bus	ness/industry	
212	filed with Hygiene other tha	Com	9	College (1-4or 5+)		Studen	t		LaPlat	a High	School
and		Be	17. Father's Name (First, Middle, Last)  Timothy Brown						Maiden Surname,		
Maryland 21	s 1 and 2 should but the alth and Menta them 27 is marked other traumatic events.	To	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street	Alyvet	ral Route Numbe	inson or, City or Town, Si	tate, Zip Code)	
Š	and 2 salth a n 27 le		Alyvetta Swinson		430 LaP1	Nanjemo	y Drive				
altimore,			20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Remo	valificiti State	lace of Dispos cemetery, crem	sition (Name of natory or other plac	e)	Date	20c. Location - C		
Ħ	permit. Page Department of Important: If eny Injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signeture of Funeral Service Licensee.	Tı		Mem.Ga	rdens	11/12/	07 Wal	dorf,M	d.
ä	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		Danice Edi	warde	3	Name and Address 910 Sil	ver Hil	l Rd.,	Suitla	nd, Md	.20746
	Physician		23a. Par 1 Enter the disease, or complication show, or heart failure. List only one commendate Cause (Final disease or condition	ons that caused the deat ause on each line. Multiple						Approx Interva Onset	ximate al Between and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		165 60 1	read, N	eck and	chesc		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Doe to (or as a conseq	иепсе об:						
>	certificate be executed ding physicien and use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
8/60,	e be ex rsicien e buria	icai E	d =	200 10 (01 00 0 0011000	-						
9	ntificating physics as the		IF FEMALE:								
X Q	atter for u	Physician/Med	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ideath 3□	Ectopic pregnancy			23d. Date Monti		Year
<u>.</u>	0 0 0	hysic		9 Unknown	eath 5	Other (specify)					
<u>ა</u>	as the	by P	Part II. Other significant conditions contrib	iting to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause	of death?
ecord	w require been sig should t	Completed						1 D Y		Probably 4	
Ř	e la hes ye 2	dmo							sy pri rmed? de	ere autopsy findi or to completion ath?	of cause of
	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical				26. Place of Dea			Yes 2 No	
=	Sir Sir	မှ	examiner?  Yes 2 No  Hosp	I 🗀 inpatient 2 🗀	ER/Outpatient		4 🗀 Nursing n		lence 6 🕱 Other		ushop R
5	ding th. : After funer	tion:	- Entatoral o Entang	8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World	/ at ⟨? Yes 2 <b>⊠</b> No	more Ye	low injury occurred	ecolic	A.
DIVISION	r Atter er dea rector by the	ertificatio	3 Cuicide 6 Could not be	8e. Place of Injury - At he building, etc. (Specif	ome farm stre	et factory office		28f. Location (S	Street and Number	or Rural Route	Number,
2	oltal or urs aft sral Di	O	1-46	Tawnyan	es			janny	aplata,	MO	20033,2
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera	dicai	(Check only 2 Medical Examiner:	in: To the best of my kno On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tin estigation, in my of	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mani date and place, an	ner as stated. d due to the cau	nse(s)
	To the Complete Compl	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (		
			> Yulia M. Ta				550583		NOV. 1	2. 200	57
	)		30. Name and address of person who completely address of person who completely address of person who c			Print)	646				
	Sta	te	31. Date filed (Month, Day, Year), NOV 1 7 2007	eled cause of death (Iten	role	rates					
	Registr	ar	MAA T 1 5901		3						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11/05/2007 Yeer **Physician** Month 10:25 PM Dorothy A. Slacum /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 8/24/1912 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🗓 F Virginia 95 Yrs Director 223-05-7648 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be ruillised at 1 XYes 2 □ No Be Completed by Funeral Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 Glenburn Avenue, #102 21613 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after in nent of Health and Mental Hygiene. Int: If Item 27 Is marked other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life DO NOT use retired)

Executive Director 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Community and Elementary/Secondary (0-12) College (1-4or 5+) Emergency Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Grace Tucker 2 Herbert Milton Allev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynda Freeman/Daughter 27142 Coach House Ln., Salisbury, MD 21801 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of P
Important: If ite
eny injury or ot
once. MidShoreCremationCenter 11/7/2007 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Scrature of Fun-ray ervice License. 22. Name and Address of Facility
Gurran-Bromwell Funeral Home 2PAA
308 High St., Cambridge, MD 21613 231 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** carcinoma, disease or condition resulting in death) years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 2 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4 □ Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certificate funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes > No 3□ DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) 12 Easton, MD 21601 MID Crowley, MD 610 Dutchmans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

07-08201 Anna Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	1- For State AMEND#7,8 Per FH	f Maryland / Depart 10/29/07 CMHCert				T DESCRIPTION	Reg. No.	200	17 3691
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last) Anna Margaret Thom	nn con				2. Date of De Month	Day 21, 2007	Year 3	. Time of Death 1211 hrs
11 Exami	ner	4a. Facility Name (if not institution, give s			b. City, Town, or	Location of E			ounty of Death	
		Bowie Health Center			Bowie			Prin	ce George's	3
Funeral	•	Social Security Number     6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year			3irth(MM/DD/	YYYY) 9. Birth	place (State or
Director		216-30-4710 <sub>1_N</sub>	$_{1} \ _{2}X_{F} \ \overline{73} \ 75$	Yrs	Months Days	Hours	Min. 10/04	/ <del>1934</del>	Cour	laryland
		Usual Residence of Decedent								10d. Inside City Limits
v any		10a. State 10b. County Maryland Prince (	George's 10c. City,	Town or Locati	ion				1	1XX Yes 2 No
land f sho		, , , , , , , , , , , , , , , , , , ,			1406 7: Ondo			10g Citizen	of What Counti	
MOTE, MID ZIZIOUSO Pages I and 2 should be filled within 72 hours after death with the Maryland rent of Heath and Mortal Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Mc first Examiner must be notified at once.	Director	10e. Street and Number 5603 Church Road			10f. Zip Code 20720	)		_	S.A.	
with ns 23 be no	ral		12. Was Decedent Ever in U. Armed Forces?		is Decedent of His		? ( Specify Yes or I	No- 14.	Race - America White, etc.	an Indian, Black,
death or iter must	Funeral	1 Never Married 2 XX Married	1 Yes XX No		_		ocito raodii, otoi,	_	T.	Vhite
raffer iner	by F		f Yes, Give Year or Dates:		Yes 2 X No		d of work done		ecify: of Business/In	
hours 'natu Exan	ted	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)		ost of working life			100.74	0.200	
in 72 than	ple	12	College (1-4 of 51)	Secret	arv			Off	ice	
Definition of the many of the many of the many of the many of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Mc Ken	Completed by	17. Father's Name (First, Middle, Last)				18.Mother's	Name (First, Middle	e, Maiden Su	rname)	
ntal Hiked o	Be (	William Kackritz					L Mae Thi			
d Mer s mar tic ev	2	19a. Informant's Name/Relationship (Typ					er or Rural Route N			Zip Code)
id 2 sh llth an m 27 i auma		Ed Thompson/ Husba		1 -	Church E sition (Name of ce		Bowie, Ma		ation - City or 1	Fown, State
Pages 1 and 2 should be filed within 72 hours after death ment of Health and Montal Hygiene. fant: If item 27 is marked other than "natural", or ite or other traumatic event, the Mc Ken Examiner must		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	crematory or ot rt Line	her place)					
Page ment c tant: or otl		4 Donation 5 Other Specify:	Cer	neterv						Maryland
ermit. Separti mpor		21. Signature of Funeral Service License	ee	- 1			Robert E			
	_	23a. Part I. Enter the disease, or complic	cations that caused the death		000 Anna	rpolis such as car	Road, Bo	wie. Narrest, shock	<u>∕larvLanc</u> , or heart	Approximate interval
hysician Medical		failure. List only one cause on each	h line.		, ,					Between Onset and Death
≟xaminer	8 5		Multiple Injuries  Oue to (or as a consequence of	of):						
		Sequentially list conditions, b								
	Je	if any, leading to immediate D	due to (or as a consequence of	of):						
_	Examine	(Disease or injury that initiated	oue to (or as a consequence of	of):			_			
ansit	Ä	events resulting in death) Last d.		·						
OX GO/OU,  eath certificate be executed attending physician and for use as the bunal - transit	dical	UNPENDED	AMENDED							
ou, cate be physici he buri	ĕ	IF FEMALE:	23c. If yes, outcome of preg	nancy					Date of delivery	
certificate nding physes as the b	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth  A Pregnant at time of de		etal death 3	Ectopic	oregnancy	\ \ \ \ \ \ \	Month D	Day Year
e death of the attented for us	sic	1 Yes 2 No 9 V Unknown	9 Unknown	5 C	Other (Specify)			·		
			contributing to death but not	resulting in the	underlying cause	given in Par				the cause of death?
tha det	À						1 _	Yes 2	No 3 Prob	pably 4 Unknown
es be	Completed						24a. W	Vas an utopsy		topsy findings available completion of cause of
requires been sign rould be	ᇛ				<u> </u>			erformed? es 2 No	death? 1 ✓ Ye	es 2 No
e law requires that the deat e has been signed by the att ge 2 should be detached for					26.Pla	ce of Death (	Check only one)			
The lavicate ha	B B	examiner?	ospital: 1 Inpatient 2 ✓	ER/Outpatier	nt 3 DOA	Other4	Nursing Home 5	Residen	ce 6 Othe	r:
The lav	٠.٧	27 Monnos of Dooth	28a. Date of Injury	28b. Time of	Injury 28c. In	jury at Work?	28d. Descr	ibe how injur	y occurred	er auto and truck
The lay icate ha	בַּוֹ			1110 hrs	1 1	Yes 2 🗸		ito side sv	wiped arioti	ci auto ana traon
The lavicate happed 2		1 Natural 5 Pending	Oct 21, 2007		'	163 2	a pole			
The lavicate happed 2		1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	on 28e. Place of Injury - At I				28f, Locati	on (Street an	d Number or Ru	ural Route Number, City
DIVISION OF VICE INCOMING OF UNITS HE LAN UNITS HER CHEER CHEER HE LAND HE CHIERCHE HE HE LINES THE LINES HE LI	ertification:	1 Natural 5 Pending 2 ✓ Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At the (Specify) Major Roa	home, farm, str ad / Highwa	eet, factory, office	building, etc	28f. Location or Tow 197 at Old	vn, State) I Chapel Ro	oad, Bowie, M	ID
Hospital or Attending Physician: The law 34 hours after death.  Funeral Director: After this certificate ha ely filled in by the funeral director, page 2	Certification:		28e. Place of Injury - At I	home, farm, str ad / Highwa	eet, factory, office	building, etc	28f. Location or Tov 197 at Old	vn, State) I Chapel Ro cause(s) and	oad, Bowie, M I manner as stat	ID ted.
Hospital or Attending Physician: The law 34 hours after death.  Funeral Director: After this certificate ha ely filled in by the funeral director, page 2	Certification:	(Check only one)  2 Medical Examiner:	28e. Place of Injury - At the (Specify) Major Roa	home, farm, str ad / Highwa	eet, factory, office y urred at the time, ation, in my opinio	e building, etc date and plac on, death occ	28f. Location or Tov 197 at Old	vn, State) I Chapel Ro cause(s) and date and place	pad, Bowie, M I manner as stat ce, and due to th	ted. ne cause(s)
DIVISION OF VICE INCOMING OF UNITS HE LAN UNITS HER CHEER CHEER HE LAND HE CHIERCHE HE HE LINES THE LINES HE LI	ertification:		28e. Place of Injury - At I (Specify) Major Roa an: To the best of my knowler on the basis of examination	home, farm, str ad / Highwa	eet, factory, office by urred at the time, ation, in my opinion	date and place on, death occurse number	28f. Location or Tov 197 at Old	vn, State) I Chapel Ro cause(s) and date and place	pad, Bowie, M I manner as state, be, and due to the pate signed (Mo	ted. ne cause(s) onth, Day, Year)
Hospital or Attending Physician: The law 34 hours after death.  Funeral Director: After this certificate ha ely filled in by the funeral director, page 2	Certification:	Certifying Physicia (Check only one) 2 Medical Examiner:  29b. Signature and title of certifier	28e. Place of Injury - At I (Specify) Major Roa an: To the best of my knowler con the basis of examination and manner stated.	nome, farm, str. ad / Highwa dge, death occ and/or investig	eet, factory, office by urred at the time, ation, in my opinion	e building, etc date and plac on, death occ	28f. Location or Tov 197 at Old	vn, State) I Chapel Ro cause(s) and date and place	pad, Bowie, M I manner as stat ce, and due to th	ted. ne cause(s) onth, Day, Year)
Hospital or Attending Physician: The law 34 hours after death. Funeral Director: After this certificate ha ely filled in by the funeral director, page 2	Certification:	Certifying Physicia (Check only one) 2 Medical Examiner:  29b. Signature and title of certifier  30. Name and address of person who compared to the compared t	28e. Place of Injury - At I (Specify) Major Roams: To the best of my knowler on the basis of examination and manner stated.	home, farm, strad / Highwaddge, death occand/or investig	eet, factory, office	date and plate on, death occurse number	28f. Location or Tow 197 at Old ce, and due to the curred at the time, of	vn, State) I Chapel Ro cause(s) and date and place	pad, Bowie, M I manner as state, be, and due to the pate signed (Mo	ted. ne cause(s) onth, Day, Year)
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate ha empletely filled in by the funeral director, page 2	Certification:	29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who certifier  Ling Li, MD Assistant Mo	28e. Place of Injury - At I (Specify) Major Roa an: To the best of my knowler On the basis of examination and manner stated.	home, farm, strad / Highwaddge, death occ and/or investig	eet, factory, office  y  urred at the time, ation, in my opinion  29c. Lice O.C.	date and plate on, death occurse number	28f. Location or Tow 197 at Old ce, and due to the curred at the time, of	vn, State) I Chapel Ro cause(s) and date and place	pad, Bowie, M I manner as state, be, and due to the pate signed (Mo	ne cause(s) onth, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** No 10 2007 Year 12:45 Sally Virginia Watkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert . Age (In yrs. last birthday) 86 Yrs. 8. Date of Birth Junger, Day, Year 921 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F 242-36-4990 North Carolina Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County Maryland Calvert Prince Frederick 1 ☐ Yes 2 ☐ X o Director 10f. Zip Code 20678 10g. Citizen of What Country?
United States 10e. Street and Number 85 Hospital Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 凝☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 ■Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) uńknown homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Tugman Monroe Vannoy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14532 Perrywood Drive Burtonsville MD Karen McLain- granddaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of Nov 16 <sup>D</sup>**2**007 Carolina Memorial Park 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State Kannapolis NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Island Rd. Port Republic MD ) OUU. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause gareach, line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical p (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last quence of) Examiner The law requires that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph I for use as t IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MORTIC STENOSIS 1 Yes 2 No 3 Probably 4 Onknown Completed INFLAMMATORS BOUGE DISGRISE 24a. Was an Were autopsy findings available prior to completion of cause of cate has by page 2 s ANGMIA autopsy death? 1 □ Yes 2 □ No perform IABETES 1∐ Yes To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Leartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 50233 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD GLYNIS PRINCE FREDERICK. HOSPITAL OR D 110 31. Date filed (Month, Day, Year) 38. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

07-08301
Aubrev Jer

brey Jerome \ -2-11		erson State of M 1-For State Amend#1.PerMF0P0C11 Registrar Amend# S6.10f.18.19a	aryland / Depa	artment of <i>rµțificate of</i>	Hea Dea	th and th	Menta		Reg. No	200	7 3694
Physicia dical Exami	an/	Decedent's Name (First, Middle,Last)	WILKERSON WILKINSON					2. Date of De Month October	Day	Year	3. Time of Death 0956 hrs
Cai Laaiiii		4a. Facility Name (if not institution, give stree			lb. City,	Town, or Lo	cation of I		4	4c. County of Death	
		7954 Cryden Way				stville	15 ( ) - 1 6	Odulin To Date of f		Prince George	
Funeral Director		5. Social Security Number 6. Sex 1 X M = 217-11-9405	7. Age (In yrs.	last birthday) Yrs.	Mont	ler 1 Year Days	If Under 2 Hours	Min. 12-20		M/DD/YYYY) 9. Bir Foreig Co	
any		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Locati	on						10d. Inside City Limits
<b>≱</b>	L	Maryland Prince Geor		Forestv		,					1 *Yes 2 No
darylar 28a-f s I at on	Director	10e. Street and Number	50 5	1010001	10f. Zi	p Code			10g. C	citizen of What Cou	ntry?
h the N 23a or 10tifie		6537 Hil Mar Drive				20737				U.S.A.	67
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral		Vas Decedent Ever in U urmed Forces? Yes 2 ★ No					n? ( Specify Yes or I Puerto Rican, etc.)	<b>4</b> 0-	White, etc.	ican Indian, Black,
after de		3 Widowed 4 Divorced If Yes, or Dat	Give Year	1	Yes	≱ No	specify:			Specify: B1a	ack
hours natura Exami	ted b	15. Decedent's Education (Specify only high				l Occupation		nd of work done se retired)	.16b	. Kind of Business/	Industry
5-0036 iled within 72 Hygiene. I other than '	Completed by	12th	Silege (144 of 34)	Se	cur	ity Of	ffice	r	P	rivate In	ndustry
15-0 illed wi Hygie d other		17. Father's Name (First, Middle, Last)		•		18	3.Mother's	Name (First Midel	ker.	en Surname) SON	
2121 ald be i Mental marke	o Be	Austin Gray  19a. Informant's Name/Relationship (Type, P	rint )	19b. Mailing	Addres			ia D. Willer or Rural Route N		City or Town, State	e, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Felicia D. <del>Wilkinson</del>	/mother								<del>9737</del> —20747
of Heal		20a. Method of Disposition  1 Burial 2 Cremation 3 Re	moval from State	Place of Dispos crematory or otl	ner plac	e)		Date		c. Location - City or	
ltim it. Pag rriment ortant:		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Ce	edar Hil		emete: d Address o		11-03-200	0/1/5	ouitiand,	Maryland
Ba Depa Imp		Mary Hedgman Mi	1374					11 PA Ave	e. S	Suitland,	MD 20746
Physician /Medical		23a. Part I/Enter the sease, or complication failure. List only one cause on each line			he mode	of dying, s	uch as car	diac or respiratory	arrest, s	shock, or heart	Approximate Interval Between Onset and Death
≟xaminer			ple Gunshot Wou (or as a consequence								Death
	_	Sequentially list conditions, b.	(or as a consequence	of):							
	Examiner	cause. Enter Underlying Cause				٠		<u> </u>		<u> </u>	
uted nd ransit	Exa	events resulting in death) Last Due to d.	(or as a consequence	or):							
50, te be executed ysician and burial - transit	ledical	UNPENDED	ENDED								
Box 68760, a death certificate be the attending physic ed for use as the but		23b. Was decedent pregnant in the	. If yes, outcome of pre		etal deat	3	Ectopic	pregnancy		23d. Date of deliver Month	ry Day Year
Box 6876.  The death certificate y the attending phy	Physician/N	past 12 months?  1 Yes 2 No 9 Unknown 9	Pregnant at time of o		ther (Sp	ecify)					
O. B. it the de la the la the la the		- Control of the cont	onknown ibuting to death but not	resulting in the	underlyi	ng cause gi	ven in Parl	t I. 23e. Di	d tobac	co use contribute to	o the cause of death?
Vital Records, P.O. hysician: The law requires that the this certificate has been signed by all director, page 2 should be detach	ed by										obably 4 V Unknown
ords aw requas beer 2 shoul	Completed								as an itopsy irformed	prior to	utopsy findings available completion of cause of
Rec The l ficate l	Com			<del></del>		26 Pleas	of Dooth //	1 ✓ Y∈ Check only one)		No 1 🗸 Y	
/ital /sician /sician is certi	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	al: 1 Inpatient 2	ER/Outpatient	3		Othor:	Nursing Home 5	Res	sidence 6 🗸 Oth	er: Scene
Division of Vital Records, rad or Attending Physician: The law required at fact death.  all Director: After this certificate has been sited in by the funeral director, page 2 should be	n: To	27. Manner of Death	Ba. Date of Injury OUND:	28b. Time of FOUND:	Injury		at Work?	Subject s		injury occurred	
Sion Attend r death. ector: by the f	catic	2 Accident Investigation	Oct 25, 2007 8e. Place of Injury - At	0948 hrs	et facto		es 2 🗸 I	1000	n (Stree	et and Number or F	Rural Route Number, City
Division pital or Attencours after death	ertifi	Suicide Could not be	(Specify) inside vel		or, radio	,,, 000 00	manig, oto			y, Forestville, MD	
Hos Frre tely	Medical Certification:	29a. Certifier 1 Certifying Physician: T	the best of my knowle	dge, death occu	rred at t	ne time, dat	e and plac	ce, and due to the c	ause(s)	) and manner as sta	ated.
To the Hos within 24 h To the Fur completely	Medi	one) 2 Medical Examiner: On the and selection of the selection of the and selection of the	ne basis of examination manner stated.	and/or investiga		ny opinion, 9c. License		aned at the time, 0		ed. Date signed (M	
	-	1.1.11-	land To	,		O.C.N		OCME	ı	October 26, 200	
(2)		30. Name and address of person who complete							201		
			Assistant Medical 32. Registrar's Sign		1111	enn Str	eet, Balf	timore, MD 212	201		
S	tate	31. Date filed (Month, Day, Year)	52. Negisital S Sign								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:32 a<sup>M</sup> October | 30, 2007 Beatrice White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 29 Shelton Court Prince Georges Indian Head If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2/C3KF June 5, 1930 Director 77 424-42-0076 Jefferson, Al. Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No Maryland Indian Head Prince Georges Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "Instrument of Health and Mental Hygiene", refers 23a any liqury or other traumatic event, the Medical Examination 29 Shelton Ct. 20640 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Johnson Pollis Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2997 Stockholm Way Woodbridge, Va. Gregory White / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Lawn Nov. 7,2007 Buffalo, N.Y. 21. Signature of Funeral Service Lice 22. Name and Address of Facility
Alexander S. P
5538 Mariboro Pope Pikė/Forėstville, Md. 20747 23a. Part . En ir the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) yrs. **Physician** Multiple Myeloma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the chiral of Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-tra Due to (or as a consequence of): attending physician for use as the hurial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed by , page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2**√** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 X Yes 2 □ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or A To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Stonature and title of certifier 29d. Date signed (Month, Day, Year)

10

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

John

31. Date filed (Month, Day,

NOV 0 2 2007

E. McKnight, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

De15185

1160 Varnum Street N.E. #108 Washington, D.C.

November 1, 2007

20017-2180

			1 - For Amend	Items	State o 23a,25 p	of Marylar <b>xer me, g</b>	nd / Depa <b>3874 , 12</b>	artment of H	lealth a	nd Mental I	Hygiene	רחח	36950
P	Physic	an	1. Decedent's Name	e (First, Middle,	Last)		000	tillicate of	Dealii	2. Date of Month	5 5-10	Year	3. Time of Death
	/Medi	cal		YLVESTE		umb a cl		4h Cihi Toum o	r I cootian at	NOVEN	IBER 2	2007	10:42 a M
7	Examir	ier	4a. Facility Name (In					4b. City, Town, o		Death		nty of Death	
1677	Funeral		5. Social Security N		. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days				DERICK 9. Birthp	place (State or Foreign
	Director		215-44-98		<b>★</b> M 2□F	61	Yrs.	World's Days	riours		5, 1946	Mary	
	land ow		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	cation				·	10d. Inside City Limits
	Mary a-f sh	tor	Maryland	Freder	ick	Fr	ederic	k					1 ☐ Yes <b>2K</b> ☐ No
	h with the 23a or 28 st be not	al Director	10e. Street and Nur 4310 Ba1		Creek Pi	ke		10f. Zip Code <b>2170</b> 3	3		10g. Citizen d USA	of What Cou	ntry?
9036	be filed within 72 hours after death with the Maryland that Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1  ☐ Never Marri 3  ☐ Widowed		Armed F	2 □ No ive		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origi an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No- 14. F B Spe	Race - Americ Black, White, city:	
1215-(	within 72 h ene. than "natu he Medical	Completed	(Spec		Education grade completed) College (	1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most ( d)	of working		Business/In	·
2	filed w Hygiei other th		12 17. Father's Name (	Firet Middle L	net)		Furna	ce Operat		a Nama (First Mis		uminu	<u> </u>
/lanc	should be fand Mental Band Mental Band Mental Bandsked of umatic ever	To Be		S. Wil	•					s Name <i>(First, Mid</i> <b>Leanor Sm</b>		ame)	
Mary	nd 2 alth a 27 is r trau	·	19a. Informant's Na Peggy Wil				19b. Mailir <b>4310</b>	ng Address <i>(Street</i> <b>Ballenge</b>	and Number	or Rural Route Nu	mber, City or Tow <b>Frederic</b>	vn, State, Zip k, Ma	ryland 21703
Baltimore, Maryland 21215-0036	Pages 1 a nent of Hee int: If item iry or othe		20a. Method of Disp 1 X Burial 2 [ 4 Donation	Cremation 3	□Removal from			sition (Name of matory or other place n Memoria	се) 1 11	Date6-2007	20c. Location	•	•
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Fu	neral Servic	censee _	Ell		2. Name and Addre		Staurre	r Funera rederick		e yland 21702
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)  Sequentially list confirming to immediate. Enter Indea Cause (Disease or I that initiated event) Leading to death).	ditions, mediate lying	a. Due to	caused the deat each line.  Cor as a consector to the correction of the correction o	uence of);  Performed off);	er the mode of dyir		erdiac or respirator		EXAMINE	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	dical			ľ		,	of B-Cell	. Lympl	noma			
P.O. Box	Attending Physician: The law requires that the death certificate be executed rotesth. The death of death of the description and ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 I 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1 ☐ Live I	tcome pf pregna pirth 2 □ Feta nant at time of d own	al death 3□	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
Records, P	w requires that s been signed b should be deta	þ	Part II. Other signifi	cant condition	s contributing to d	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		id tobacco use co □ Yes 2 🛣 No		he cause of death? pably 4 □Unknown
II Reco	Physician: The faw ruthis certificate has be al director, page 2 sh	Completed								24a. W au po 1	utopsy erformed?	prior to co death?	opsy findings available mpletion of cause of
Vita	ician: certific ector,	Be	25. Was case referr examiner?		Hospital:			Tout		f Death (Check on	ly one)		
0	Phys	<u>۲</u>	1 Yes -2 Yes	<del>+</del>	28a. Date	Inpatient 2  of Injury	ER/Outpatien 28b. Time of		4 LI Nurs	ing Home 5 ☐ R	esidence 6 🗆 Coe how injury occ		(y)
on	nding th. :: Afte e fune	tion	1 Natural 2 ☐ Accident	5 Pending investigat	(Mon	th, Day Year)	Injury	28c. Injun Worl	k? Yes 2 ⊟No		se now injury occ	unea	
Division or Vital	al or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d Zoe. Flace	of injury - At he ing, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location City or	n (Street and Nur Town, State)	nber or Rura	al Route Number,
	Hospita 4 hours Funera tely fille	Medical C	29a. Certifier (Check only one)	1 ☐ Certifying 2 ☐ Medical Ex	aminer: On the b	best of my kno asis of examina ner stated.	wledge, death	occurred at the tire estigation, in my o	ne, date and pinion, death	place, and due to to occurred at the tire	he cause(s) and ne, date and plac	manner as s e, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	itle of certifier				29c. License	e number		29d. Date sign	ned (Month,	Day, Year)
)			1 mg	us lo	Lee N	/am		000	135	106	NOV	2, 6	2007
	8x1		30. Name and address Myung H	ss of person wh	o completed caus 400 West	se of death (Iten 7th St	123a) (Type, F						/
	Sta Registr		31. Date filed (Monti	NOV 0	32. R	legistrar's Signa	ture	perti					-

DHMH 17 Rev 1/2001

		State Registrar		Ce	rtificate of	Death		Reg. No. 2	07 26051
		Decedent's Name (First, Middle, Late	ist)				2. Date of De	eath	3. Time of Death
Physicia /Medic		Hans M. W	Joodward				Octobe	r 31, 20	11:30 P M
Examine		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat		4c. County	
	A.		ourt			mont			ederick
Funeral Director		220-76-7750	Sex 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year   Months   Days		(Month, Da	1, 1957	9. Birthplace (State or Foreign Country) <b>Nigeria</b>
and and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Mary -f sho	ţō	Maryland Frederi	.ck 1	Thu <b>rm</b> ont	<b>:</b>				Yes 2 No
3a or 28s	al Director	10e. Street and Number  14 Terben Court			10f. Zip Code <b>21788</b>			10g. Citizen of W	/hat Country?
	by Funeral	11. Marital Status  1 □ Never Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No rto Rican, etc.)	14. Race Black Specify:	e-American Indian, k, White, etc. <b>White</b>
72 hou "natura	Completed	15. Decedent's Ec (Specify only highest gra	ducation	16a. Dece	dent's Usual Occu	pation during most of wo	orking	16b. Kind of Bu	siness/Industry
within iene. than the Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)			chen des:		Kitche	n designing
other /ent, t	Be C	17. Father's Name (First, Middle, Last)	)		· · · · · · · · · · · · · · · · · · ·			, Maiden Surnam	θ)
wuld be Menta arked arked	TO B	David Earl Woodwa	ırd			Eleono	r Bhre	ndt	
2 sho and l is ma		19a. Informant's Name/Relationship (	Type. Print)	19b. Maiti	ng Address (Stree	t and Number or R	ural Route Numb	er, City or Town,	State, Zip Code)
1 and lealth om 27 ther to		Tammy Woodward - W 20a. Method of Disposition			erben Cou	rt, Thur	mont, Ma		21788
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Denation 5 ☐ Other (Specify	Removal from State	cemetery, cre	matory or other plane Memoria				City or Town, State  k, Maryland
permit. Departimporti		21. Signature of Funeral Service Licer	nsee Oly	I .		ess of Facility S			
EXTREME	1				rozi nbos	sumtwon	rike, rr	ederick,	maryrand 217
Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.  a. AVAN  Due to (or as a cons	eath. Do not en			c or respiratory a		Approximate Interval Between Onset and Death
executed wand in and in-transit	al Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.  a. Advan	eath. Do not en		ing, such as cardia	c or respiratory a		Approximate Interval Between Onset and Death
/Medical Examiner be executed by physician and street burial-transit as the burial-transit by the burial-trans	edical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leads to the cause. Enter Underlying Cause (Disease or injury that initiated events	a. A V An Due to (or as a cons b. Due to (or as a cons c	eath. Do not en		ing, such as cardia	c or respiratory a	irrest,	Approximate Interval Between Onset and Death IB mo attus
res that the death certificate be executed a migned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, In the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d.  23c. If yes, outcome pf pre 1 Live birth 2   F 4 Pregnant at time of	sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of):	ter the mode of dy  Lung  BEctopic pregnant  Other (specify)	ing, such as cardia	c or respiratory a	23d. Date Mor	Approximate Interval Between Onset and Death I B mo attus
aw requires that the death certificate be executed by the attending physician and as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	b. Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d.  23c. If yes, outcome pf pre 1 Live birth 2   F 4 Pregnant at time of	sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of):	ter the mode of dy  Lung  BEctopic pregnant  Other (specify)	ing, such as cardia	23e. Did 1 24a. Was auto	23d. Date Mor  tobacco use contri  Yes 2 \( \subseteq \) No  an 24b. V psy psy p	Approximate Interval Between Onset and Death  Be of delivery on the Day Year  iibute to the cause of death?  I Probably 4 Unknown  Vere autopsy findings available rior to completion of cause of eath?
The law requires that the death certificate be executed at the death certificate be executed at the base been signed by the attending physician and an angle 2 should be detached for use as the burial-transit	Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any leading to introduce (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of the	b. Due to (or as a cons  b. Due to (or as a cons  c. Due to (or as a cons  d.  23c. If yes, outcome pf pre 1 Live birth 2   F 4 Pregnant at time of	sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of):	ter the mode of dy  Lung  BEctopic pregnant  Other (specify)	cy ven in Part I.	23e. Did	23d. Date Mor	Approximate Interval Between Onset and Death I B mo attus  e of delivery on the Day Year sibute to the cause of death?  3 Probably 4 Unknown  Vere autopsy findings available prior to completion of cause of
The law requires that the death certificate be executed at the death certificate be executed at the base been signed by the attending physician and an angle 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions of	Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)  Due to (or as a const.)	sequence of): sequence of): sequence of): sequence of): sequence of): sequence of): sequence of):	Ectopic pregnand Other (specify)	ey  ven in Part I.  26. Place of De	23e. Did 1 1 24a. Was auto perfit	23d. Date Mor	Approximate Interval Between Onset and Death  I B mo xttls  e of delivery  th Day Year  ibute to the cause of death?  3 Probably 4 Unknown  Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
ng Physician: The law requires that the death certificate be executed the result of the second of the result of the second of th	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of the conditions of the carminer? 1  Yes 2 No 27. Manner of Death	Due to (or as a constant time of the contributing to death but not a contributing to death but not a constant time of the contributing to death but not a cont	eath. Do not en	□Ectopic pregnand □ Other (specify) □ Inderlying cause gi	ey  ven in Part I.  26. Place of Deher: 4 \( \text{Nursing } \)	23e. Did 1 24a. Was auto perfit 1 Yes ath (Check only the content of the content	23d. Date Mor Ves 2 No 24b. V pry Pry Pry 2 No 1	Approximate Interval Between Onset and Death I I I I I I I I I I I I I I I I I I I
ng Physician: The law requires that the death certificate be executed the result of the second of the result of the second of th	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, It say leading to include the cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions of the caminer? 25. Was case referred to medical examiner? 1   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2   No   Yes 2	Due to (or as a constant to the contributing to death but not a contributing to death but not	eath. Do not en  Ce d  sequence of):	□Ectopic pregnanc □ Other (specify) □ Int 3□ DOA Other MC Interest Section 1 □ 28c. Interest Se	ey  ven in Part I.  26. Place of Deher: 4 \( \triangle \) Nursing First  vk?  1 Yes 2 \( \triangle \) No	23e. Did 1 24a. Was auto perfi 1 Yes ath (Check only Home 5 [PResi	23d. Date More tobacco use control of the second se	Approximate Interval Between Onset and Death I I I I I I I I I I I I I I I I I I I
ital or Attending Physician: The law requires that the death certificate be executed that is after death.  In a director: After this certificate has been signed by the attending physician and in pilled in by the funeral director, page 2 should be detached for use as the burial-transit and in pilled in by the funeral director, page 2 should be detached for use as the burial-transit.	o Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a constant of the constant of th	eath. Do not en	DECtopic pregnant ☐ Other (specify) ☐ 28c. Inju W M 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐	ey  ven in Part I.  26. Place of Deher: 4 Nursing First?  Yes 2 No	23e. Did 1 24a. Was auto perfit yes ath (Check only) 28d. Describe 28f. Location (City or To	23d. Date More tobacco use control of the second se	Approximate Interval Between Onset and Death I B mountles  e of delivery year  ibute to the cause of death?  3 Probably 4 Unknown  Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No  er (Specify)  ed  er or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\*\*Ranan Hudhud, MD 468 Thomas Tohnson Tohnson Tohnson Tohnson 21702

31. Date filed (Month Day, Year)

32. Reflictive's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:30 P M Mary Ellen Wilbanks October 30 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Cherry Lane Nursing Center Prince Georges Laurel 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F Director 577 42 2839 78 7, 1929 Washington DC Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location ir than "netural", or iteme 23a or 28a-f ehow the Nedical Examinational be notified at 1 ☐ Yes 2 No Director Glenwood MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15257 Callaway Court 21738 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 No 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: If Yes, Give Year or Dates: Specify 3√2 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clive Newton Thompson Fannie Vines Sawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marshall O. Combs/Son 15257 Callaway Court Glenwood, MD 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or ' 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 11-2-2007 | Brentwood, MD 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 a 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Failure to Thrive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physiclan/Medical Examiner attending physician and for use as the burial-transit Dementia resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Depression page 2 s performed? 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe November 1, 2007 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perse College Park, MD Adebowale Ajayi 6201 Greenbelt Rd.
Régistrar's Signature 31. Date filed (Month, Day, Year State NOV 02 Registrar

		,	1- For State of Maryland		artment of H			giene 200	7 36953
	Sec.	-	1. Decedent's Name (First, Middle, Last)  2. Date of Death						3. Time of Death
	Physici		Sherman Louis Walker				Novem	ber 5.200	LA LA
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of		4c. County of Dea	
	LAGITIII		11700 Basswood Drive		Laure	a ]		Prince	Georges
· 诶 F	uneral		5. Social Security Number 6. Sex 7. Age (In yrs. las		If Under 1 Year Months Days	II Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th 9 Bi	rthplace (State or Foreign
	irector		231-46-3688 <sup>1⊠M 2□F</sup> 7	0 Yrs.	Months Days	riouis	Sept.1	3,1937	VA
2	2 10		Usual Residence of Decedent  10a. State 10b. County 10c. City, 7	Town or L	reation				10d. Inside City Limits
laryla	eho M	٦ ا			All I				1 ⊠ Yes 2 □ No
he ⊼	or 28a-f ehow rengilled at	ect	Md. PG  10e. Street and Number	Lau	10f. Zip Code			10g. Citizen of What C	
with	D O	급	11700 Basswood Drive			708		United S	
flied within 72 hours after death with the Maryland	"naturel", or iteme 23a or 28a-f ehov adical Examiner coust be notified at	Funeral Director	11, Marital Status 12. Was Decedent Ever in U.S.	13.			n? (Specify Yes or No		
ter d	Iner	Ë	Armed Forces?  1 Never Married 2 Married 1 Yes 2 1 No	1.0.	If Yes, specify Cubai	n, Mexican, I	Puerto Rican, etc.)	Black, Wh	
urs al	, i	b	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specify:	.ack
2 2	cal	Completed		16a. Dece	dent's Usual Occupa	ition	d warden a	16b. Kind of Busines	
thin 7	Mad	ed l	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life.	kind of work done d DO NOT use retired;	)	i working		
N De	a a	Son	12	Grou	ind Atter			Govern	ment
2 2	d oth	Be	17. Father's Name (First, Middle, Last)				s Name (First, Middle	,	
should	is marked other then aumatic event, Italia	2	Joseph Walker			Bert	ha Fran	klin	
2 sh	I neath and mental ryylene. Item 27 is marked other then "n other traumatic event, ILE Macil				ng Address (Street a			er, City or Town, State,	Zip Code)
and	m 27 i				el Md . esition (Name of				
Pages 1	# ite		20a. Method of Disposition 1	e of Dispo letery, crei	osition (Name of matory or other place	9)	Date	20c. Location - City o	r Town, State
mit. Pages	iury (		4 ☐ Donation 5 ☐ Other (Specify) Res					Clinton,	
semit.	Important: if item 2  eny injury or other  once.		21. Signature of Funeral Service Licensee		2. Name and Addres			& Edwards	
	3.0		23a. Pan Enter the disease, or complications that caused the death.						, Md. 20746
			should or heart failure. List only one cause on each line.	DO HOL BIT	tor the mode or dying	y, such as ce	ardiac or respiratory a	11031,	Interval Between Onset and Death
	/sician ledical		disease or condition a. Cardiac A.	rrth	ymia				
	aminer		Due to (or as a consequer	•					
		-	Sequentially list conditions, if any, leading to immediate  b. Hyperkalem: Due to (or as a consequent	ia morofi:					
* pe	nsit	를	Cause (Disease or injury	1200					
be executed	n and al-tra	Examiner	that initiated events resulting in death) Last C. RENAT FAILS  Due to (or as a consequent consequen						
e be ex	physicien and the burial-transit	dical	d						
The law requires that the death certificate	g ph) as th	edi							
ath cert	signed by the ettending p d be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal de		Dectopic pregnancy			23d. Date of d	
98 3	e ett	ICIa	in the past 12 months?  1   Yes   2   No   9   Unknown		Other (specify)			Month	Day Year
) g	by th	hys	9 ☐ Unknown						
es the	gned eb ec	by F	Part II. Other significant conditions contributing to death but not resulting	tobacco use contribute	ute to the cause of daath?				
radari	been si should I					· · · · · · · · · · · · · · · · · · ·	1	Yes 2 No 3 F	Probably 4 23Unknown
N N	as be 2 sho	Completed					24a. Was		autopsy findings available completion of cause of
ag I	ete ha	E O					perfo	ormed? death?	
i i	ortifica ctor, I	Be	25. Was case referred to medical examiner?			26. Place o	of Death (Check only		
ıysic	dire.	10	Hospital:	∛Outpatiei	nt 3 DOA	or: 4 □ Nurs	sing Home 5 🔀 Resi	idence 6 Other (Sp	ecify)
ב ב	iter th		27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	8b. Time o	l 28c, Injury Work	at ?	28d. Describe	how injury occurred	
ending	or: Al	atle	2 Accident investigation			res 2 □ No	0		
rAn	rect.	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At homicide building, etc. (Specify)	e, farm, st	reet, factory, office		28l. Location ( City or To	Street and Number or I wn, State)	Rural Route Number,
) lel	re led								
Hosp	within 44 hours arter the gradu.  To the Funerel Director: Alter this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier  1 ★ Certifying Physician: To the best of my knowle  2 ★ Medical Examiner: On the basis of examination	edge, deat n and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
the	the mplel	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mor	nth Day Yearl
P 1	8 4 8		b Can Miller In	$\Omega$			_		
			gay Jum, VII	1/1		02195	5	11/10	0/07
	81		30. Name and address of person who completed cause of death (Item 2						
COL Maria	Sta		Jay Ocuin, M.D., 106 Irvin	g St	NIAT I	Vashi:	ngton, Do	20010	
	Regist		Jay Ocuin, M.D., 106 Irvin 31. Date filed (Month, Day, Year) 32. Registrar's Signatur NOV 1 7 2007	J. 13	A CANAL				
		A		- 69					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner VA MediCAL JALT MURE DALT MORE Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 XM 2 □ F 82 233-44-5080 06/05/1925 Director West Virginia Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Director Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 1709 Earhart Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Electronics 8 Wireman permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, is 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jackson Aronhalt Nellie Biggs ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1709 Earhart Road, Essex, Maryland 21221 Ethel Mildred Aronhalt - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/23/2007 Middle River, Maryland Holly Hill Memorial 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Loud C. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□ Unknown 9 ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 ☑ No certificate 1□ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 Hipatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 TYes After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 4 hours after death. 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10 North Greens Street Baltimore ms 2120/ ause of death (Item 23a) (Type, Print) 30. Name and address of person who completed SchWART2 GARY T. 32. F. gistrar's Signature 31. Date filed (Month, Day, Year) State NOV2 0 2007 Registrar

DHMH 17 Rev 1/2001

PROVIDED TO PLANT MATERIAL PROPERTY (Fig. Mode). Last)  Provided To Plant Material Provided To Country  Seat of Country Material Provided To Country  Belliminate Country  Bellim				State Registrar	ne or iviaryiand		rtificate of I		Re	g. No.2007	36955
Examiner  (a) Early Name (if not membroice, part societies and namely)  (b) Early Road  (c) Ea	6										
Part   Part	0				und number)						
Source   The Country   The C								If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 19	9. Birth 1940 Balti	place (State or Foreign more, Maryland
Company of the control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control and the		rland ow at			10c. City	, Town or Lo	cation				10d. Inside City Limits
Company of the control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control and the		he Man 8a-f sh otified	ector		Balt	imore C					
Company of the control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control are referred   The control and the	Q	th with the 23a or 2	al Dir				1000		10		ntry?
Colored February   Section   February   Section	SHE	urs after deal al", or items ( examiner mu	by	1 Never Married X Married 1 If Y	ned Forces? ]Yes 2 <b>xx</b> No ′es, Give				cify Yes or No- Rican, etc.)	Black, White,	etc.
23a. Fartt. Enter the disease. Or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Modifical Examiner	5-0	"natura	leted	15. Decedent's Education (Specify only highest grade comp	nleted)	16a. Deced	dent's Usual Occup	ation during most of workir	ng 1		
23a. Fartt. Enter the disease. Or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Modifical Examiner	212	d withir giene.	Somp							Housekeeping~	Own Home
28. Fartt. Enter the idease. Or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Medical Examiner   Medical Exa	MH and	d be file ental Hy ked othe c event,	o Be C	1 ' ' '						laiden Surname)	
23a. Fartt. Enter the disease. Or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Modifical Examiner	  ary	2 shou and M is mar raumati	F		nt)	1			·		Code)
23a. Fartt. Enter the disease. Or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Modifical Examiner	Z, P	s 1 and f Health item 27 other to		20a. Method of Disposition	20b. PI						own, State
23a. Fartt. Enter the disease. Or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arest.    Physician   Modifical Examiner	timo	. Page: tment o tant: If fury or		4 ☐ Donation 5 ☐ Other (Specify)	u nom State	ly Hill	Memorial G	ardens Nov.	20 2007 B	Baltimore, Mar	yland
23a. Fartt. Ear the disease, Promipilations that caused the death. On one enter the mode of dying, such as cardiac or respiratory arest, shock, or heart statistic bill on your cause on each line. The shock or heart statistic bill on your cause on each line. The shock or heart statistic bill on your cause on each line. The shock or heart statistic bill on your cause on each line. The shock or heart statistic bill on your cause on each line. The shock or heart statistic bill on your cause on each line. The shock or heart statistic bill on the shock or heart stat		permit Depar Impor any in once.	13 9	21. Signature of Funeral Service Licens, e	ohn	4.1:	assahn Fune	ral Home Inc	omo Morral	and 21226	
The part of the part 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes, outcome pf pregnancy in the past 12 points?  23c. If yes 2 lost of the past 12 poin	7	/Medical Examiner	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury that initiated events c.	Due to (or as a consequence to	Do not enter January Jence of):	er the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Orget and Death Orget Approximate Interval Between Orget Approximate Interval Between Orget Approximate Interval Between Interval
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	. Box	t the death certificat by the attending phy ached for use as the	sician/M	23b. Was decedent pregnant in the past 12 months?	☐Live birth 2☐Fetal☐Pregnant at time of de	death 3		,		I	*
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	rds, P	quires that n signed t	þ	Part II. Other significant conditions contributin	ig to death but not resul	Iting in the ur	nderlying cause give	en in Part I.	5.00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	l Reco	The law re ate has bee page 2 sho	omplete						autopsy perform	prior to co	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	ion or Vita	nding Physician: th. : After this certific e funeral director,	To Be	examiner? 1  Yes 2 No Hospita  27. Manner of Death 1 Natural 5 Pending	Date of Injury	28b. Time of	28c. Injun	er: 4 Nursing Hon y at 2 k?	ne 5 Resider	nce 6 Other (Speci	fy)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	Divisi	al or Atter s after dea il Director ed in by the	ertifica	3 Suicide 6 Could not be 28e	Place of injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  William Waterfield 9103 Franklin Square Drive Suite 2200 Baltimore, Maryland 21337  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		e Hospit 24 hours e Funera letely fille		(Check only 2 Medical Examiner: O	n the basis of examinati	wiedge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and manner as s ate and place, and due t	stated. to the cause(s)
State 31. Date filed (World), Day, Tear)	•	To th within To th сощр	Me	· Ch Culate	efect !	m				. /	
BH 3 . BY ABI			te_	William C. Waterfield	d cluse of death (Item  903 Frow  32. Registrar's Signat	uie	Print) Guare Dri	ve Suite	2200 Bo	Himore, Mary	bund 21237

		1- State of Maryland / E		tment of H		and Me	ental Hy	giene ,	2007	36957
Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
Physici /Medic		Dorothy M. Ashley					ovembe		2007	3:00 A M
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	of Death			ounty of Dea	
		Cherry Hill Nursing 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	irthday)	Laure1	If Under:	24 Hrs T	8. Date of Bi			eorge 's
Funeral Director		404 055		Months Days	Hours	Min.	May 17	y, Year)	9 D.	thplace (State or Foreign ountry)
		Usual Residence of Decedent					2147 27	,	, ,,,	
ırylan show	_	10a. State 10b. County 10c. City, Town	n or Loca	ation						10d. Inside City Limits
ne Ma 8a-f s	Director	MD Prince George's Colleg	ge Pa							1 ☑ Yes 2 ☐ No
with the		10e. Street and Number		10f. Zip Code				10g. Citize	n of What Co	ountry?
eath	eral	9509 50th Place  11. Marital Status 12. Was Decedent Ever in U.S.	13 W	20740	enanic Orio	gin? (Spec	ify Vac or No	U.S.A		erican Indian,
aryland 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at	by Funeral	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		as Decedent of His Yes, specify Cubar ☑Yes 2፟፟፟ No	Specify:	n, Puerto R	ican, etc.)		Black, Whit	
2 hou	ted	15. Decedent's Education 16a.	. Decede	nt's Usual Occupa	tion			16b. Kind	of Business	
212 thin 7 an "r Med	nple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	life. DO	nd of work done do NOT use retired)	uring most	t of working	9			
21 ed wi ygien ygien t, th	Completed		omema							
be fill hall H	Be	17. Father's Name (First, Middle, Last) Paul Jackman					First, Middle	, Maiden Su	ırname)	
ryla hould d Me mark matic	은		Mailing	Address (Street a			Dove	or City or T	'aum Chata	Tin Code)
Ma nd 2 s ulth an 127 Is r trau				Sutting D						zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examlone.		20a. Method of Disposition 20b. Place of		tion (Name of atory or other place		Da			tion - City or	Town, State
Page Page nent c int; if		1 Bullat 2 (2) Clemation 3 Hemoval from State		ln Crem.	4	11/16	/2007	Bren	twood	. MD
mit.		21. Signature of Funeral Service Licensee		Name and Address	of Facility	y Ft.	Linco	oln Fu	neral	Home
		Merane a: Coffells	34	401 Blade	ensbu	rg Rd	l., Br	entwoo	d, MD	20722
		23a. Part1. Enter the disease, or complications that dauged the death. Do n shock, or heart failure. List only one cause on each line.	not enter	the mode of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Complications from Alzheimer's disease								Onset and Death
Examiner		Due to (or as a consequence of):								
	- Le	Sequentially list conditions,  Due to (or as a consequence of):								
outed Id	Examiner	Cause (Disease or injury that initiated events								
e exercian ar										
box 68/60, death certificate be executed e attending physician and d for use as the burial-transit	dical	d								
EOX 6 leath certific attending p	Mec	IF FEMALE:								
BOX eath cer attendir for use	hysician/Me	23b. Was decedent pregnant in the past 12 months?  □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		ctopic pregnancy Other (specify)				230	<ol> <li>Date of del Month</li> </ol>	ivery Day Year
the dy the colored	ysic	1 ☐ Yes 2 ☒ No 4 ☐ Fregnant at time of death 9 ☐ Unknown	300	ruler (specify)						
w requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions contributing to death but not resulting in	n the und	erlying cause giver	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
w require							10	Yes 2🄼 f	No 3□Pr	obably 4 Unknown
law re as bee	Completed						24a. Was		24b. Were au	utopsy findings available
The law	E C						auto perfo	rmed?	death? 1 ☐ Yes	completion of cause of 2 ☐ No
VITAL IN Include The sicilar: The certificate rector, pag	Be (	25. Was case referred to medical examiner?		1		of Death (	Check only o			
his by a light	2	1	tpatient		4 KM NUI		∋ 5 ☐ Resi			cify)
SION tending leath. for: After the funer	tion	1 X Natural 5 □ Pending (Month, Day Year) Ir	Injury	28c. Injury Work?	at } es 2∐N		d. Describe	how injury o	ccurred	
Atten Atten death	fica	3 Suicide 6 Could not be	ırm, stree			_	f. Location (	Street and N	lumber or Ru	ural Route Number,
al or all or all or all Direction to	Certification:	4 Homicide determined building, etc. (Specify)					City or To	vn, State)		
To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	e, death o	occurred at the time stigation, in my op	e, date and inion, deaf	d place, ar th occurred	d due to the	cause(s) an date and pl	d manner as ace, and due	s stated. e to the cause(s)
To the within To the comp	M	29b. Signature and the of certifier		29c. License	number			29d. Date s	igned (Mont	h, Day, Year)
		Kellylls m.O		D435	51			11/16	/2007	
3		30. Name and address of person who completed cause of death (Item 23a) (Tikechi Okwara, MD 6201 Green			ite (	U <b>-</b> 15	Colleg	ge Par	k, MD	20740
Sta Registra		31. Date filed (Month, Day, Year)  NOV 2 0 2007	Snow	S. J.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician Donald. Malcolm Andrews 17, 2007 4c. County of Death /Medical November 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 507 Amberly Road Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Pay, Year) Nov. 4,1921 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2□F MD 86 215-18-2264 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 507 Amberly Road 21060 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 14 Bace - American Indian. Items : 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1♥ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 6 Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Completed by 3 Widowed 4 Divorced "natural" tal Hygiene.
I other than "natura event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be fi Department of Health and Mental t Important: If Item 27 is marked ot any linjury or other traumatic ever once. Thelma G. Roberts Doughty Andrews ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 507 Amberly Road Glen Burnie MD 21060 Mrs. Betty J. Andrews /Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Nov. 21. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 22. Name and Address of FacilitySingleton Funeral & Cremation 21. Signature of Juneral Service Licensee MO1411 Services 1Second Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carreer **Physician** MOW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 40 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21100 has e 2 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 1 ☐ Yes Hospital: 2 No 2 ER/Outpatient 3 DDA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 A Natural 2 Accident 28b. Time of Certification: After 5 Pending investigation M 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the 29c. License number 29b. Signature and title of certifier Son who completed cause of death (Item 23a) (Type, Print)

Markan 305 (Noshital Try, Glan Burnil, MD. 2106) hay M.D 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dhish 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Doris Madelynne Allen November 18, 2007 0510 AM /Medical 4c. County of Death 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 90 Min. 1 □ M 2 🗓 F Yrs. August 15, 1917 Maryland Director 215-14-6736 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes X☐ No Woodlawn Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 19 Summerfield Road United States of America Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth May Ennis John Francis McNulty ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9617 Hillridge Drive, Kensington, Maryland 20895 Victoria M. Belle (Friend) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 11/21/07 Catonsville, MD. 21228 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facilitoring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): 2 weeks ancer /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregna 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 100 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 25. Was case referred to ical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 | atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3□ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determine 4 Homicide within 24 hours a To the Funeral L 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ROSENBERG

31. Date filed (Month, Day, "Year)

32. Registral's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 19 **Physician** Year 2007 10:384 M Ester Brown /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Keswick Nursing Home** Baltimore Social Security Number if Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 Y Yrs. Director 223-03-9603 88 April 15, 1919 VA Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Director 1XYes 2 No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1816 Penrose Avenue 21223 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ▼ No Specify: Specify. 3 ₩Widowed 4 Divorced Year or Dates: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If Item 27 is marked other th. any injury or other traumatic event, the once. Riveteer <u>Glen L. Martin</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lewis Billups Daisy STokes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 Penrose Ave. Baltimore, MD Vernon Brown/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date tsBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Mem.Pk. 11-23-2007 Laurel, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility James A. Morton & Sons F.H., Inc. ames 1701-31 Laurens St. Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ereors-vascular duease + mutyle strokes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -trans Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 \\ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an certificate 1□ Yes 2 1 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 | Natural 5 Pending investigation within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Fo the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1

DHMH 17 Rev 1/2001

State Registrar D13657

700 W. 40th STREET, BALTIOTARE, MY 21211

Nevember 19,2007

Misabelle The gran or D

OR BABELLE MOESREGER,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Redistrar's Signature

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

no

31. Date filed (Month, Day, Year)

401

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Kay November 2007 /Medical Sandra Butcher 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millenium Nursing Home Ellicott City Howard Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth 12/4/1962 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖬 F 216-84-3754 44 Maryland Director Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov dical Examiner must be notified at MD 1 □Yes 2 No Director Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1214 Stevens Ave 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify Specify: 3 Widowed 4 Divorced white other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Administrative Assistant</u> Communications Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fii and Menta! H Be Benjamin G. Springer Gail Wolsch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Kenneth W. Butcher / husband 1214 Stevens Ave Arbutus, Maryland 21227 permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial 11/20/2007 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Incrose Funeral Home, Inc. ice License 1328 Sulphur Spring Rd Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conse of) ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of and the attending physician are the for use as the bunal-Due to (or as a consequence of) Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 20 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Danch Sa bapathi 201-109 Rack Rival WCK Road Balhowse Hayland 212)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 2

0

32. Segistrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Geneva Ann Barnes 2007 November 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1500 Rayville Road Parkton Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 💢 F 242-12-3000 84 July 15, 1923 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Maryland | Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1500 Rayville Road 21120 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 **X**No 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager Credit Union 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leno Renfro Dora Jane Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Barnes - Son 305 Skyline Drive, Elkhorn, Nebraska 68022 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Holly Hill Memorial 11/20/2007 Middle River, Maryland 21. Signature of Funeral Screen Licur 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Acute Renal Failure 2 weeks Due to (or as a consequence of): Metastatic Cancer 6 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 2 No 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nasidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

ပ

**Funeral** 

Director

show at 28a-f sh notified

a or ns 23a

'natural", or items dical Examiner mu

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natur
important: If Item 27 is marked other than "natur
important: If Item 27 is marked other than "natur
important: If Item 37 is marked other than "natur
important: Item 37 is marked other in the Medical E
once.

with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Division or Vital Records.

burial-trar attending physician as the nse jo the detached ģ signed to been page 2 s certificate this

Examiner funeral After t the

law requires that the death certificate be executed Physician: Hospital or Attending 24 hours after death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by

0 Registrar

Physician/Medical þ Completed Be P Certification: ical

> 31. Date filed (Month, Day, Year) 2007 NOV 2 0

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

27. Manner of Death

1 XNatural

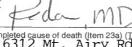
2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)



28a. Date of Injury (Month, Day Year)

29c. License number D0063271

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy B. Pedone, 16312 Mt. Airy Rd., Shrewsbury, Pa. 17361

32 Registrar's Signature

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature any DKYSICIA M 42723 . NOVEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NONTH WEST BOSSITAL AVVERAHALLI BARISH. COUNT 5401

Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 0 2917

2007

CENTER

ROAD

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:10a<sub>M</sub> Juanita Faye Basham Nov 14 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1000 Franklin Avenue Essex Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 7, 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Kentucky 85 407-07-9377 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Essex 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1000 Franklin Avenue 21221 USA by Funeral death 1 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural", or fler other traumatic event, the Medical Examiner 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Winder Cotton Mill 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Earl Strunk Myrtle Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Kelly Dugan / niece 405 N. Carolina Avenue Pasadena MD 21122 Department of Health Important; if Item 27 any injury or other tr once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 11/17/07 Baltimore MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocordia /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jinknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has be irector, page 2 s performed? Yes 2 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification:

Division or Vital Records, To the Hospital or Attending Physician: After this funeral nours after death.
Ineral Director: Af within 24 hours at To the Funeral Completely filled it

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29b. Signatur

29c. License number D&3465

29d. Date signed (Month, Day, Year)

16 (4

address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a

OAKWOOD ROAD Glen Burnie 7845 31. Date filed (Many 32 Registrar's Signature Dorms

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Da **Physician** November BIJAN BROWN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Hospital Baltimore Cit JINA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 17 Months Hours Min 593-06-9760 NEW YORK Director 9/30/1990 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Determent of Health and Mental Hygiene. Imprortant: If item 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at N/A BALTIMORE CITY XXYes 2 □ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 3400 DUPONT AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 【XNo Specify: þ 3 Widowed 4 Divorced Baltimore, Maryland 21215-003 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT STUDENT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CONNIE HITCHCOCK ROGER BROWN letrent Knainau ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) 3400 DUPONT AVE, BALTIMORE, CONNIE HITCHCOCK-JOHNSON/ MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEM. 11/24/07 WINDSOR MILL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of peral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD er the sease, or complications that caused the desheart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease Condition Physician Status diseas condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2 No 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1□ Yes 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Inpatient 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending 5 Pending investigation death. 1 Yes 2 No 2 Accident I Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) November 17 2007

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of pers

31. Date filed (Month, Day, Year)

NOV 2 0 2007

ise of death (Item 23a) (Type, Print)

MD

Registrar's Signature

Sinai

		State of Maryland					•	e.				
		For State State Registrar		rtificate of i		, ,	g. No. 2 A A	7 00000				
		1. Decedent's Name (First, Middle, Last)				2. Date of Death	200	3. Time of Death				
Physici /Medic		Amelia Br	150	لم		Nov		ear 007 0922M				
Examin		4a. Facility Name (If not institution, give street and number)		The second secon	r Location of Death	1	4c. County of	Death				
4		BALTO WASh Med Ctr		If Under 1 Year	BUY:	use of Dist	1+	H				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 M 2 NF 75	as <i>t birtnaay)</i> Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 7, 1)	Year)	Birthplace (State or Foreign Country)  MD				
		Usual Residence of Decedent				Jan. 7 , 1	732	rib				
arylan show d at	_		, Town or Lo	ocation				10d. Inside City Limits 1 □Yes 2XNo				
he Ma	ecto		adena	105 75- 0-1-			O.W / 10/L .					
with t	i	10e. Street and Number 317 Magothy Blvd.		10f. Zip Code 21122			g. Citizen of Wha	.t Country?				
ms 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S	S. 13.		lispanic Origin? (Spanic Origin?)		14. Race -	American Indian,				
or ite	.E	Armed Forces?  1 Never Married 2 Married 1 ZM No If Yes, Give		1 ☐ Yes 2 ☒ No	an, mexican, Puerto  Specify:	Hican, etc.)		White, etc. White				
ural",	d by	3 May Widowed 4 □ Divorced Year or Dates:										
n 72 t	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of worki d)	ing 1	6b. Kind of Busin	ess/Industry				
l withi jiene. r thar the M	E O	Elementary/Secondary (0-12) College (1-4or 5+)		d Service	.,		Educa	tion				
e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M						
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eximiner must be notified at once.	卢	Henry Glass	r		Caroli	ne Shoos	ter					
12 sho		19a. Informant's Name/Relationship (Type. Print)			and Number or Rura							
1 and Healtl em 27		Lewis Brison Jr. /Son  20a. Method of Disposition 20b. Pla	ace of Dispo	osition (Name of	SE Glen	Date 2	Mary Lan  Oc. Location - Cit					
ages ent of t; If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	metery, cre	matory or other place. 11 Cemete	Nov	. 21,		•				
nit. Partme		21. Signature of European Service Licensee Mo141					Brooklyn meral &					
Der Imp any		21. Signature of Fare (a) Service Licensee  Moiul   22. Name and Address of Facility Singleton Funeral & Cremation Service 1 Second Avenue SW Glen Burnie, MD 21061										
		23a. Part1. Enter the disesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
Physician		Immediate Cause (Final disease or condition  Arteries cleretic Heart Disease  Onset and Death										
/Medical Examiner		resulting in death)  Due to (or as a consequence of):										
-A	<u></u>	Sequentially list conditions, b. Due to for set a consequent										
uted	Examiner	cause. Enter Underlying Cause (Disease or injury										
be executed ician and burial-transit	Exa	that initiated events ' c										
ate be nysicia he bui	<u>ca</u>	d										
The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE:										
attend for us	ian/	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of de	death 3	⊒Ectopic pregnancy ⊒ Other (specify)	/		23d. Date o Month					
the d	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown										
w requires that the dibeen signed by the should be detached	by Pt	Part II. Other significant conditions contributing to death but not result	Iting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?				
equire:						1 ☐ Yes	s 2 □ No 3[	Probably 4 Unknown				
ne law re has be ge 2 sho	Completed					24a. Was an autopsy		re autopsy findings available r to completion of cause of				
sician. The la certificate har irector, page 2	E O					perform	ed? dea	th? Yes 2 □ No				
iclan: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Oth	26. Place of Death	(Check only one	f . h					
Phys	٠. ۲	1 Impatient 2 E	R/Outpatier 28b. Time o	nt 3 DOA Othe	4 □ Nursing Ho	me 5 Resider 28d. Describe how		Specify)				
nding th. : After e fune	ţi	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury	Worl	k? Yes 2∐No	LOG. DOSCINGO NO	vingury occurred					
Atter	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hombuilding, etc. (Specify,	me, farm, sti	reet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,				
tal or rs afte al Dir	Certification:	Tomora Sunang, etc. (Specin),	,	_		Only of Town,	Olale)					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to		29a. Certifier 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating the control of the basis of the control of the basis of the control of the basis of the control of the basis of the control of the control of the control of the control of the basis of the control of t										
the ithin 2 the omplei	Medical	one) and manner stated.  29b. Signature and title of certifier	. 1.1 . 1	29c. License	e number	29	d. Date signed (A	Month, Day, Year)				
F 3 F 8		V/11.11. 00 -	477	D	06099	+	11/19	17				
10		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)			/	1035				
10		William P. Sones	ms	0 69	5 A.	meric	A 2	1035				
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signati										
Registr	ar	NOV 2 0 2007	fin for	parker	· · · · · · · · · · · · · · · · · · ·							

ysician Medical	_	Decedent's Name (First, Midd	lle, Last)					2. Date of Dea Month			3. Time of Death
		Cornelius Baum	ngardner					October		0 <sup>Y</sup> 7 <sup>ar</sup>	11:00 PM
aminer		. Facility Name (If not institution					Location of Death		4c. Count	y of Death	
		3800 Forest Pa	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Fore
eral ector		215-80-7515	1 <del>√</del> 2 M 2□F	39	Yrs.	Months Days	Hours Min.	June 4	, Year) , 1968		ington D
tes.	Us	sual Residence of Decedent la. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c Cit	y, Town or Lo	cation				1	0d. Inside City Limi
in pa		MD	,		altimo					,	ty⊡Yes 2□t
Director	10	e. Street and Number			,are inc	10f. Zip Code		1	l0g. Citizen of	What Coun	ntry?
ad la		3800 Forest	Park Aven	ue #D			21215			USA	
Funeral	11	. Marital Status un	12. Was De	cedent Ever in U. Forces?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ	
Mical Examiner must be nutified at leted by Funeral Director		1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes. G		ınk	1 ☐ Yes 2 🂢 No	Specify:		Speci	'n bla	.ck
ted!		15. Decede	nt's Education		16a. Deced	dent's Usual Occup	ation	unk	16b. Kind of E	Business/Inc	dustry <del>UT</del>
t, the Medical	-	(Specify only high) Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+)	life.	kind of work done of DO NOT use retired	during most of work	ang	automo	hila	industr
the Co		ink 11	unk		Mech	anic	40 Markada Nama	- (5i A A A A A A A A			ur ur
To Be	5	7. Father's Name (First, Middle Cornelius B		r		<del>unk</del>	18. Mother's Nam Angela	Barbara		me <i>j</i>	<del></del>
aumatic event, the Mi	19	9a. Informant's Name/Relation antrice Baumga	ship (Type, Print)	aster-	1	ng Address (Street a					
har tr	B	Baltimore Gity	Police D	ept siste		2 Brooksh			rlboro 20c. Location		
eny injury or other traumatic event, the Maulical once.  To Re Commisted	20	a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (		n State C	emetery, crer	natory or other plac		Date	20¢, Location	- City or To	own, State
eny Inju	21	1. Signature of Euneral Service Ronald	dicentage	Director		Name and Address altimore,			Baltim	ore S	treet
	2	3a. Part . Enter the disease, o shock or heart failufe. Lis	of complications that	t caused the death					est,		Approximate Interval Between
cian		nmediate Cause (Final isease or condition		Mus	202	elial	ntarch	hon			Onset and Death
lical iner	re	esulting in death)	Due to	o (or as a consequ	uence of):	1					
à	Ş	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Diseese or injury	b. — Due to	o (or as a consequ	uence of):	beter	Melh	t s		-	
	Ca Ca	ause. Enter Underlying	<								
		at initiated exents				Hom l	· · ·			1	
rial-transit		at initiated events is sulting in death) Last	c	o (or as a consequ	uence of):	ityple	2-714				
the burial-tra		at initiated events	c	o (or as a consequ	uence of):	Agre	2-71				
se as the burial-tra		at initiated events soutling in death) Last	d			ityple	) · · · ·		224.0		
for use as the burial-tra		at initiated events issulting in death) Last  FEMALE:  3b. Was decedent pregnant in the past 12 months?	d	outcome of pregna	incy	Ectopic pregnancy				ate of delive	ery Day Year
ached for use as the burial-tra		at initiated events issulting in death) Last  FEMALE: 3b. Was decedent pregnant	d	outcome of pregna b birth 2 ☐ Fetal gnant at time of de	incy	DEctopic pregnancy	2 , , , ,				•
be detached for use as the burial-tra	IF 23	at intitated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	outcome of pregna b birth 2  Fetal gnant at time of de known	incy I death 3 (eath 5 (	Other (specify)			bacco use con	ntnbute to th	Day Year
be detached for use as the but	IF 23	at initiated events soutling in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	d	outcome of pregna b birth 2  Fetal gnant at time of de known	incy I death 3 (eath 5 (	Other (specify)			М	lonth	Day Year
should be detached for use as the but	IF 23	at initiated events soutling in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	d	outcome of pregna b birth 2  Fetal gnant at time of de known	incy I death 3 (eath 5 (	Other (specify)		1 🗆 Y	bacco use cores 2 \( \sum \) No	anthbute to the second of the	Day Year
should be detached for use as the but	Pa Pa	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown art II. Other significant condit	d	outcome of pregna b birth 2  Fetal gnant at time of de known	incy I death 3 (eath 5 (	Other (specify)	en in Part I.	1  Yas a autop perfor	bacco use cor les 2 No lan sy med?	ntribute to the	Day Year  the cause of death?  pably 4 Onknot  psy findings availal  mpletion of cause of
should be detached for use as the but	Fa	at intiated events issulting in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant condit	d	outcome of pregna s birth 2 ∏ Fetal gnant at time of de known death but not resu	incy I death 3 [ eath 5 [ ulting in the u	Other (specify)	en in Part I.  26. Place of Dea	24a. Was a autop perfor 1 Yes	bacco use cores 2 □ No an 24b. sy med? 20 No	onth  3  Prob  Were auto prior to co death? 1  Yes	Day Year  the cause of death?  pably 4 Monknor  posy findings availal  mpletion of cause of
should be detached for use as the but	Pa	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	d	putcome of pregna birth 2 Fetal gnant at time of discrete consumers of the	incy I death 3 [ eath 5 [ ulting in the u	Other (specify)	en in Part I.  26. Place of Dea er: 4   Unursing H	1  Yas a autop perfor	bacco use cores 2 \( \text{No} \)  an 24b.  y med?  text 2 \( \text{No} \)  ence 6 \( \text{Ott} \)	anthbute to the strength of th	Day Year  the cause of death?  pably 4 Monknor  posy findings availal  mpletion of cause of
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	Pa	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	al Hospital: 1 28a. Dat (Motigation	putcome of pregna shirth 2   Fetal gnant at time of de known death but not result	incy death 3 cath 5 cat	Other (specify)	en in Part I.  26. Place of Dea er: 4   Unursing H	1  Y  24a. Was a autop perform 1  Yes  th (Check only performe 5 Residence)	bacco use cores 2 \( \text{No} \)  an 24b.  y med?  text 2 \( \text{No} \)  ence 6 \( \text{Ott} \)	anthbute to the strength of th	Day Year  the cause of death?  pably 4 Monknor  posy findings availal  mpletion of cause of
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	Pa	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  art II. Other significant condit  warminer? 1   Yes 2   No 7. Manner of Death 1   Watural 5   Pend inves 3   Suicide 6   Coulc	al Hospital: 1 [Modified in other leads of the control of the cont	putcome of pregna birth 2 Fetal gnant at time of discrete consumers of the	eath 3 = eath 5 = eat	Other (specify)  Inderlying cause give  at 3 DOA Other  28c. Injun Work  M 1 DOA	en in Part I.  26. Place of Dea er: 4 □ Nursing H	24a. Was a autop perfor 1 Yes  th (Check only prome 5 Resid 28d. Describe h	bacco use corres 2 \( \text{No} \)  an symed?  24b.  27b.  an ow injury occur  treet and Num.	antibute to the street of the	Day Year  the cause of death?  pably 4 Monknor  posy findings availal  mpletion of cause of
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	Pa 25	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	al Hospital: 1 [28a. Dat ing tigation did not be mined]	putcome of pregna shirth 2 Fetal grant at time of discrete consum death but not result and the consum death but not result and the consum death but not result and the consum death but not result and the consum death but not result and the consum death but not result and the consum death	eath 3 = eath 5 = ulting in the u	Other (specify)	en in Part I.  26. Place of Dea er: 4 □ Nursing H y at k? Yes 2 □ No	24a. Was a autop performent (Check only or ome 5 Resid 28d. Describe h	bacco use cores 2 No an sy med? 24b. 270 on injury occur treet and Num.	antibute to the state of the st	Day Year  the cause of death?  pably 4 Monknot  posy findings availal impletion of cause of  2 No  All Route Number,
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	Pa 25	at intiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  art II. Other significant condit  warminer? 1   Yes 2   No  Manner of Death 1   Matural   5   Pend inves   3   Suicide   6   Coulc   deten   6   Coulc	al Hospital:    28a. Dat (Mc tigation d not be mined   28a. Planing Physician: To the Examiner: On the	putcome of pregna birth 2 Fetal grant at time of de chown death but not result from the control of the control	ER/Outpatier 28b. Time of Injury wiedge, deatl	other (specify)  Inderlying cause give  Inder	26. Place of Dea  90: 4 Nursing H  y at  k?  Yes 2 No	24a. Was a autop perfor 1 Yes  th (Check only prome 5 Resid 28d. Describe h	bacco use cores 2 No an 24b. ymed? 21 No ence 6 Oto ow injury occu treet and Num n, State)	anner as s	Day Year  the cause of death?  pably 4 Ethkno  posy findings availal mpletion of cause of  2 Ethko  al Route Number,
il director, page 2 should be detached for use as the but To Be Completed by Physician/Medical	Pa 25 27 27 27 27 27 27 27 27 27 27 27 27 27	at initiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	al Hospital:    28a. Dat (Mc)   (Mc)	butcome of pregna birth 2 Fetal grant at time of discrete the property of the	ER/Outpatier 28b. Time of Injury wiedge, deatl	other (specify)  Inderlying cause give  Inder	26. Place of Dea er: 4 \sum Nursing H y at k? Yes 2 \sum No	24a. Was a autopperforment of the Check only or one 5 Residence 28d. Describe has and due to the correct at the time, of the correct at the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the correc	bacco use cores 2 No an 24b. ymed? 21 No ence 6 Oto ow injury occu treet and Num n, State)	were auto prior to co death?  1 Yes  Ther (Specifiered	Day Year  the cause of death?  pably 4 Monknow  posy findings availal  impletion of cause of  2 No  2 No  A Route Number,  tated,  o the cause(s)
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	Pa 25 27 27 27 27 27 27 27 27 27 27 27 27 27	at initiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	al Hospital:    28a. Dat (Mc)   (Mc)	butcome of pregna birth 2 Fetal grant at time of discrete the property of the	ER/Outpatier 28b. Time of Injury wiedge, deatl	other (specify)  nderlying cause give  at 3 □ DOA Other  A 28c. Injun  Wor  M 1 □  eet, factory, office  n occurred at the tim  vestigation, in my of	26. Place of Dea er: 4 \_ Nursing H y at k? Yes 2 \_ No	24a. Was a autopperforment of the Check only or one 5 Residence 28d. Describe has and due to the correct at the time, of the correct at the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the time, of the correct at the correc	bacco use cores 2 No an 24b. sy med? 2 ( No ence 6 Ot ow injury occu treet and Num n, State)	were auto prior to co death?  1 Yes  Ther (Specifiered	Day Year  the cause of death?  pably 4 Monknow  posy findings availal  impletion of cause of  2 No  2 No  A Route Number,  tated,  o the cause(s)
neral director, page 2 should be detached for use as the but on. To Be Completed by Physician/Medical	25 27 28 28 28	at initiated events southing in death) Last  FEMALE: 3b. Was decedent pregnant in the past 12 months? 1	al Hospital: 1 28a. Dat (Mctions dinot be mined 28e. Plaining Physician: To the and materials and materials an	putcome of pregna is birth 2 Fetal grant at time of discrete frown death but not result and the control of the	ER/Outpatier 28b. Time of Injury wedge, deatt	other (specify)  Inderlying cause give  Inderlying cause give  It 3 DOA Other  A 28c. Injun  Work  M 1 DOA  The ceet, factory, office  In occurred at the time vestigation, in my office  Print)	26. Place of Dea er: 4 \_ Nursing H y at k? Yes 2 \_ No	24a. Was a autop performent (Check only or ome 5 Residence of the Check only or ome 5 Residence of the Check only or ome 5 Residence of the check only or own of the check only or own on the check of t	bacco use corres 2 No  an sy med? 24b.  27 No  an sy med? 20 No  ence 6 Ot ow injury occu  treet and Num n, State)  ause(s) and m date and place	were auto prior to co death?  1 Yes  ther (Specifiered)  inner as s, and due to ed (Month,	Day Year  the cause of death?  pably 4 Monknot  posy findings availal impletion of cause of  2 No  All Route Number,  tated, o the cause(s)  Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 0 / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Lloyd Neal Bowden November 15,2007 4:48 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2205 Pot Spring Road Baltimore Timonium 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 Year Days 1 X M 2 □ F Months 87 214-12-8075 Oct. 20, 1920 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12202 Burncourt Road #101 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Printer Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd T. Bowden Louise Weamert 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy A. Bowden/Son 2120 Corbett Road Monkton, MD 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. 16, 4 Donation 5 Dother (Specify) Baltimore, MD 21. Signature of Fun 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Inc. Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Thermo Delesia Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2☐ No 23d. Date of delivery 1 ☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medicai Examiner

physician and the bunal-transit

rector, page 2

After thi funeral of

s after death.

within 24 hours aft

To the Funeral D

completely filled in

or Attending Physician:

Completed by

Be

Certification: To

Medical

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

ပ

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

ene.

Department of Health and Mental Hygic Important: If Item 27 is marked other any injury or other traumatic event, it

with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

24a. Was an

28d. Describe how injury occurred

Yes 2 No 3 Probably 4 Unknown

autopsy 2 No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Mother (Spener hew's Home 28b. Time of 28c. Injury at Work?

2 ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description:

Description: and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kenneth Kochmann, M.D. 35 E. Padonia Road Timonium, MD 21093 31. Date filed (Month, Day, Year)-

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

32, Hegistrar's Signature 2007

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 17, 2007 **Physician** Thomas Edward Bourke, Sr 1:25 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore VA Rehab. & Extended Care Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Nov. | 8, 1919 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Mary Tand 220-07-4915 88 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be marked. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1926 Crestview Rd. 21239 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWI I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify. White Specify: 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bourke Catherine Gagner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9511 Q Kingscroft Terrace Perry Hall, MD 21128 Ms. Darlene Babusci / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VA Cem. 11/27/2007 Owings Mills, MD 4 Donation 5 Other (Specify) 21. Signature of Fulleral Service Licensee Kimberly Davidson 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rement la /Medical Due to (or as a consequence of): Examiner Disease arkinson Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) is been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidner 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 Î No 24a. Was an autopsy performe To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 210 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yeş 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) November 17, 2007

xl

State Registrar 30. Name and address of person who completed pause of death (Item 33a) (Type, Print) 31. Date filed (Month, Day, Year) NOV 2 0



Loch Raven Bonlevard Battimore, 17218

				1 - For State Registrar	State o	f Marylan	d / Depa	artment of rtificate of	Health and	Mental Hy	/giene2 0		36973
				1. Decedent's Name (First, Middle, Las	it)					2. Date of D	eath Day	Year	3. Time of Death
		Physici /Medic		Margaret Hamilton	Brant								7:10 A. M
-		Examin		4a. Facility Name (If not institution, give	street and nur	mber)		4b. City, Town,	or Location of De	ath	4c. County	of Death	
				Greater Baltimore					owson			more (	County
		Funeral Director		5. Social Security Number 100-09-6323 6. S	ex □ M 210 F	7. Age (In yrs. I	ast birthday) Yrs.	Months Days			irth 1, 1916	9. Birthpla Counti Glasge	ace <i>(State or Foreign</i> ry) OW, Scotland
		pu .		Usual Residence of Decedent		10a Cib	/, Town or Lo					10	d. Inside City Limits
		show	-	10a. State 10b. County	na Can							10	1 □Yes 2 □No
		8a-f	ectc	Maryland Baltimo	re Cour	TEY CC	ckeys				10g. Citizen of	Min at Caust	
		a or 2	급	10e. Street and Number 13801 York Road				10f. Zip Code	21030		United		
2		eath	Funeral Director		12 Was Dece	edent Ever in U.	S 13			(Specify Yes or N		ce - America	
P		itam Itam	un-	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Fo	rces?	J. 13.	If Yes, specify Cu	ban, Mexican, Pu	(Specify Yes or Nent of Rican, etc.)	Bla	ick, White, e	
E	38	ar, or	by	3 ∰Widowed 4 ☐ Divorced	If Yes, Giv Year or D	ve		1 ☐ Yes 2 ☒ No	o Specify:		Specif	v: W.	hite
1/12/300	9	2 should be filed within 72 hours after death with the Maryland I and Mental Hyglene. Is marked other than "natural", or itams 23a or 28a-f show raumatic event, I'le Modical Exicilitation at	Completed	15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occu	upation	vorting.	16b. Kind of B	lusiness/Ind	ustry
13	218	hin 7 9. Medi	ple	(Specify only highest gra	College (1	1-4or 5+)	life.	kind of work done DO NOT use retir	e during most or v red)	rorking	Greate		
1	21	er th	Con	12	02			Volun			Medica		ter
	pu	d oth	Be	17. Father's Name (First, Middle, Last)						lame (First, Middl	e, Maiden Sumar	ne)	
	yla	ould Men Men arka	은	James McInnes			,		Mary F				
C-	Maryland 21215-0036	2 sh and and Is m		19a. Informant's Name/Relationship (						Rural Route Num			
y		1 and 1ealth am 27 thar t		Mr. David I. Brant 20a. Method of Disposition	(Son/C			830 Cotto		rive M Date	alvern, P		9355 wn State
Ö	Jor	iges if its or of		1 ☐ Burial 2 🖾 Cremation 3 🗆				osition (Name of matory or other pl neral Cha	11140	V. 16,			
2	altimore,	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hyglene artment of Heatth and Mental Hyglene ortant: If itam 27 is marked other than "natural", or itams 23a or 28a-f show injury or other traumatic event, Ita Madical Extra illustrative Intilliad at e.		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Euperal Service Licer		11100		2. Name and Add		007	rorest	. 1111	,Maryland
1	Ba	permit, Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra 2002.		1 Poppey	I. Ja	N2, de	Pe	eaceful 2325 Yorl	Alternat k Road	ives Fun Timoni	eral&Cre um.Marvl	matio	n Ctr.,P.A. 21093
		Physician		23a. Pan Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final disease or condition	plication that cone cause on e	caused the death						2	Approximate Interval Between Onset and Death
		/Medical		resulting in death)	Due to	(or as a consequence	uence of):	<i>t</i>	////	20	11/10		1000
		Examiner		Sequentially list conditions.	b	STE	OP	ORNSI	5	600	10 0		
	1	pe ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consequ	uence of):		X				
	J	te be executed ysician and le burial-transit	хаш	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):		1.4	1 1/	Le.		
1	60,	te be ex ysician ne buria	calE		240 10	(0. 40 4 00004	201100 0171						
1	687	phys the			_ d					000			
K	Box (	certifica nding ph use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna					23d. Da	ate of deliver	ry
څک	B	death of attention and for u	ciar	in the past 12 mosths?	4□Pregr	oirth 2 Feta nant at time of d		⊒Ectopic pregnan ⊒ Other <i>(specify)</i>	icy		М	onth I	Day Year
200	0	t the by the ache	hys	9 ☐ Unknown	9□ Unkn	own							
Tant	Records, F	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	by	Part II. Other significant conditions of	ontributing to d	eath but not res	ulting in the t	underlying cause g	given in Part I.		tobacco use con		e cause of death? ably 4  Unknown
1	Ö	s bee	ompleted	HYPERLI	DIDE	MIA				24a. Ws		Were autor	sy findings available
IL	Re	sician: The law of certificate has breactor, page 2 sh	mo dimo	LEET CE	REBE	LLAR	57	ROKE		- aut per 1 ☐ Yes	formed?	death?	npletion of cause of
R	of Vital	an: 1 tiffica tor, p	O	25. Was case referred to medical	7,200	107/17		110110	26. Place of I	Death (Check only			
3	>	Physician: this certific ral director,	To B	examiner? 1 []} Yes 2 □ No	Hospital: 1 🔲	Inpatient 2 🗹	ER/Outpatie	nt 3□ DOA	ther: 4 🗋 Nursin	g Home 5 ☐ Re	sidence 6 ⊟Ot	her (Specify	)
1ARGARE		Jing Phys I. After this funeral di		27. Manner of Death  1 Natural 5 Pending	28a. Date	of Injury ith ay Year)	28b. Time o	of 28c. Inj		28d. Describe	how injury occu		Lost
7	Sio	andin eath. or: A	catic	2 Accident investigatio	1.15	12007	3:30		Yes 2 2 No			- 0//	ofell
2.	Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place build	e of <b>Injury</b> - At ho ing, etc. <i>(Specif</i>	ome, farm, st	reet, factory, office	e +	28f. Location City or T	(Street and Num own, State)	ber or Rural	Route Number,
		urs al	S		<u> </u>	1 1 1 1 1 1	ner	aparxi	men 1	10801	YOKK	. KD.	MPI K4
		To the Hospital or Atlanding Physician: The within 24 hours after death.  To tha Funaral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Pt (Check only 2 Medicel Exar	niner: On the b								
		o the o tha omple	Med	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date sign	ed (Month, I	Day, Year)
		⊢ s ⊢ ŏ		Bastman CA	NASIL	MO		D38	392		11/5/20	707	
		_		30. Name and address of person who	completed caus	se of death (Item	n 23a) (Type		, ,				
		6		BARBARA CAR	ROLL	MI	1.,13	801 X	ORKR	D., COC	KEYS	VILL	E,MD
		Sta Registi		31. Date filed (Month, Day, Year) NOV 2 0	2007 32. F	Registrar's Signa	iture	bark		,	1		-
		riegisti	पा	1408 %		- Shirthean and	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15,2007 3:07 P. M November Thomas Patterson Bronco, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore County Towson Gilchrist Center 8. Date of Birth (Month, Day, Year) Dec . 07, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) PA. Months Days Hours 1 M 2 F 79 Yrs 206-18-1666 Usual Besidence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 PYes 2 No Maryland n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 United States 4000 N.Charles Street Apt.303 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: W • W • I I 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Keziah Patterson Charles Bronco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (wife) 4000 N. Charles Street Apt.303 Baltimore, MD.21218 Mrs. Mary Ellen Barbara Bronco 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Nov.17,2007 Forest Hill, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 e, or complify lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only or recause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER 4EARS Due to (or as a consequence of) Sequentially list conditions, if any, saving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Mother (Specify) HDSPICE Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natura! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician and for use as the burial-transit within 24 hours after death To the Funeral Director;

Examine

Physician/Medical

Completed by

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

NOV 2 0

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

a or

"natural", or items 23a

Director

Funeral

Completed

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. sm 27 is marked other than "natural", or items 23a or 28a-f show

Department of Hear, Important; If Item 27 any Injury or other

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Box 68760,

Ö

م

Records.

Vital

Division

The law requires that the death certificate

or Attending Physician:

25. Was case referred to medical examiner?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29c. License number 29d. Date signed (Month, Day, Year) D64395 NOVEMBER 15, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 DOBERMAN, MS. N CHARLES ST, SMITE 209 BALTIMORE, ND 21204 DANIEUE 31. Date filed (Month, Day, Year)

State Registrar

	)8839 D-	4-0	Please Type or Print in Black Inde			
Jes	sica Lynn Ba		State of Maryland / Departm	nent of Health and Mental H cate of Death	711	07 3697
			Registrar  1. Decedent's Name (First, Middle,Last)	cate of Death	Reg. No	3. Time of Death
Me	Physici dical Exami				Month Day Year November 14, 2007	0745 hrs
7 7	aloui Exam		Jessica Lynn Bates  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		ath
			6330 Route 1 Room #2	Elkridge	Howard	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last bit)	irthday) If Under 1 Year If Under 24Hrs		Birthplace (State or Foreign
	Director		217 13 9742 1 M 2 F 23	Months Days Hours Min	1 - 1 - 1 - 001	Country) laryland
			Usual Residence of Decedent		10/30/11	lai y i aliu
	any		10a. State 10b. County 10c. City, Tow			10d. Inside City Limits
	Maryland 28a-f show d at once.	5	Pa. Bedford Bre	eezewood		1 Yes 2 No
	Maryl: 28a-f d at o	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	
3	vith the Maryland s 23a or 28a-f show e notified at once.		142 Ontario Rd.	15533	U.S.A.	
_	h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto		nerican Indian, Black,
	r deat or ite	튑	Never Married 2 William ed 1 Yes 2 V No			White
	s afte ral",	ò	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a	1 Yes 2 No specify:  a. Decedent's Usual Occupation (Give kind of	Specify: work done 16b. Kind of Busine	
	2 hour "natt	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret		
	36 hin 7 e. than	ple	12	Hostess	Food Se	ervice
	5.00 ed wit tygien other he M	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
	215 be fill ntal H rked ent, t	Be	Donald Dearing			neister
	21 nould id Mei is man	유	19a. Informant's Name/Relationship (Type, Print )	9b. Mailing Address (Street and Number or		
	ME nd 2 sl alth ar m 27 aum?		Christina Dearing mother  20a. Method of Disposition  20b. Place	142 Ontario Rd. Br	reezewood, Pa 155	
	ore, es l au of He If ite her tr		1 Burial 2 Cremation 3 Removal from State crem	atory or other place)		
	Limo Pagement Tant:		4 Libriation 5 Other Specify.		16/07   Baltimor	•
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fundral Service Licensee	22. Name and Address of Facility Gon	ce Funeral Service	ce P.A.
	Physician	-	26a. Part T. Enter the disease, or complications that caused the death. Do	14UUL Kitchie Hgwy.	Baltimore, Md. 2	Approximate Interval
	/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone and tramac	dol interior		Between Onset and Death
*	taminer		Immediate Cause (Final disease or condition resulting in death)  a. Methadone and tramacount for the condition resulting in death)  Due to (or as a consequence of):	ior micoxicación		
		<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			<del>-</del>
		nine	if any, leading to immediate  Due to (or as a consequence of):  Cusease or injury that initiated  Cuse  Cusease or injury that initiated			
	pd isit	Examiner	events resulting in death) Last  Due to (or as a consequence of):			
	executed ian and ial - transit	ical	d.  X UNPENDED AMENDED CO. C.		<u> </u>	
	o, 0, ce be e ysicia buria	ledi	X UNPENDED AMENDED #23a, 27, 28a-f, per grand and grand	ME 6876, 2/1/08 TT	23d. Date of del	ivery
	876 tifical mg ph as the	N/N	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	The second secon	Day Year
	Box 68760, re death certificate be the attending physicited for use as the buried for us	sician/Med	Pregnant at time of death	5 Other (Specify)		
	. Bc he dea y the a	Phy	Part II. Other significant conditions contributing to death but not result	ting in the underlying cause given in Part I	23e. Did tobacco use contribut	e to the cause of death?
	ires that the signed by t	by	art is other significant conditions contributing to death but not result	and the disconying cause given in ture.		Probably 4 Vunknown
	ds, equire een sig ould be	ompleted				e autopsy findings available
	faw re has b	nple			performed? deat	
	Re The ficate ficate	Col		26.Place of Death (Check		Yes 2 No
	ital iician s certi	Be	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER	TOther:	ing Home 5 Residence 6	Other: Scene
	n of Vital Records, ing Physician: The law required Physician: The law required this certificate has been summeral director, page 2 should	. To	27. Manner of Death 28a. Date of Injury 28l	b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
	On C anding ath. rr: Af	ţi	1 Natural 5 Pending Fnd 11/14/2007 Fn	nd 7:30 am	unk	
	IVISIOR  I or Attend after death Director:	ertification:	29e Pleas of Injury At home	, farm, street, factory, office building, etc.	28f. Location (Street and Number of	
	Division of ppital or Attending Phous after death.  Beral Director: After tilled in by the funeral	erti	4 Homicide determined (Specify) found in	motel room	6330 Rte. 1 Rm. 2 F	lkridge, MD
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	cal C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, (one) ✓ Medical Examiner: On the basis of examination and/o	death occurred at the time, date and place, an	d due to the cause(s) and manner as	stated.
	To the Hos within 24 h To the Fun completely	Medical	and manner stated.	29c. License number		(Month, Day, Year)
4		2	29b. Signature and title of certifier		November 15	
			Theodore W. Py JRy mis		140Vellibel 10	
			30. Name and address of person who completed calls of defin (Item 23st Theodore M. King, Jr., MD. Assistant Medical Exa		re, MD 21201	
		tate	31. Date filed (Month, Day, Year)  32. Resistrar's Signature			
	Regis		820 - 66	· Agreement of the second		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ent's Name (First, Middle, Last) 3. Time of Death 2007 Physician 2:51AM 13 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Saltimore ona Green Date of Birth (Month, Day, 2-03 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 ▼F **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant; if Item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD **Funeral Director** baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2121 14. Bace - American Indian. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ite 17. Father's Name (First, Middle, Last) unk 18. Ma Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State ဥ 19a. Informant's Name/Relationship (Type. Print) CA 90062 aesar permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other tonce. 20b. Place of Dispositio 20c. Location - Cit 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State 21. Signatu re of Funera Service Lice Pike, Balto., MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMY OF ATTY **Physician** TECHEMIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a consequence of It any, leading to infinedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician all for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Was a. autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 certificate 1∐ Yes or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 ☐ Yes 2|**X** No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral L | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my entities. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signat D31136

Registrar

State

31. Date filed (Month, Day, Year)

9005

KIL BRIDE

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner   Gladys   Bieberbach   Clagett   Nov 17, 2007	
4a. Facility Name (If not institution, give street and number) 5431 Old Crain Hwy  5. Social Security Number 578 09 3673  4b. City, Town, or Location of Death Upper Marlboro  Funeral Director  5. Social Security Number 578 09 3673  1 M ATT 93  Yrs.  4b. City, Town, or Location of Death Upper Marlboro  Prince Months Days Hours Min.  Whin Months, Pay, Year) Dec 18, 1913	9. Birthplace (State or Foreign Country) New Jersey
Funeral Director  5. Social Security Number  5. Social Security Number  6. Sex  1 M 2 F 93  Yrs.  6. Sex  1 Months Days Hours Min.  Usual Residence of Decedent  7. Age (In yrs. last birthday)  1 Under 1 Year   If Under 24 Hrs. Min.  Months Days Hours Min.  1 Dec 18, 1913	9. Birthplace (State or Foreign Country) New Jersey  10d. Inside City Limits
Usual Residence of Decedent	10d, Inside City Limits
Frederick Bieberbach  Anna R. Ranzweiler  Frederick Bieberbach  Iga. Informant's Name/Relationship (Type. Print)  Thomas Clagett (Nephew)  Thomas Clagett (Nephew)  Anna R. Ranzweiler  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  17300 Aquasco Farm Road, Aquasco, M	d States  - American Indian, k, White, etc.  - White siness/Industry  Le Clagett Insurance ance
20a. Method of Disposition    Description   Complete	. MD
Physician /Medical Examiner  Physician /Medical Examiner  To a graph of the container of th	7 Syears. 7 Syears. 7 Syears.
4 0/10	e of delivery nth Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions in the underlying cause given in Part I.	ibute to the cause of death? 3 ☐ Probably 4 ☐Unknown
Type 1 Check only one)    Type   Check only one)   Type   Check only on	Vere autopsy findings available rior to completion of cause of leath?
25. Was case referred to medical examiner?  1   Ves   2	
The state of the s	
The state of the s	and due to the cause(s)
290. Date signed	1 (Month, Day, Year) - 19, 2007
Main 6 Cleenspelie UD 3042049 November 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36978 Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Louise G Cacchione November 19 2007 3:25 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oak Crest Baltimore Baltimore County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) October 26 1912 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 149 18 2947 95 Italy Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Baltimore County 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be it 8820 Walther Blvd. Apt. 209 21234 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes XX No 3altimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)  $6_{1/2}$ <u>Teacher</u> Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Santina Cordelli Nicola Gori ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau 2626 Hillcrest Avenue Baltimore, Md. 21234 Linda Gasiorowski (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc November 24 2007 Baltimore Maryland 4 Donation 5 Dother (Specify) 21. g titure of Funeral Service Livenses 22. Name and Address of Facility Lassahn Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician erebrovascular accident disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No ospital or Attending Physician: The hours after death.
uneral Director: After this certificate by filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Blue Portville, MD 8800 Walther Closha Dixon MO 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

3

O

Cacchione

			1 - For State Registrar		State o	of Mar	yland		artment of F				giene Rog. No?	007	36979	
T.	Physici	an	Decedent's Name (First, Michael Elsie E Corn									2. Date of Dea		007 Year	3. Time of Death 4:45 P	
	/Medic Examin		4a. Facility Name (If not institut		eet and nu	ımber)			4b. City, Town, o	r Location	of Death	Movember		County of Death	11.10	-
	LXGIIIII	C1	Oak Crest			ľ			Baltimor					altimore		
	Funeral Director		5. Social Security Number 218 18 5983	6. Sex 1 □ N	4 2 <b>⊋</b> F	7. Age (	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt Month, Da November	<sup>h</sup> 4 <sup>Y</sup> °192	9. Birth 2 Baltin	place (State or Foreign ntry) Ore, Maryland	
	yland Now		Usual Residence of Decedent  10a. State 10b. Cour	ty		1	I Oc. City,	Town or Lo	cation				, , , , , ,		10d. Inside City Limits	_
	Ba-1 et	ctor	Maryland Balti	more			Balti	imore C	ounty						1 Tes 2 No	
	ath with the 23a or 24	Funeral Directo	10e. Street and Number 8810 Walther Blvo	l. Apt.	2128				10f. Zip Code 21234				10g. Citiz	en of What Cou A	ntry?	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itame 23a or 28a-f ehow event, the Medical Exertiner must be incitied at	by	11. Marital Status  1 Never Married 2 M  3 Widowed 4 Divorce	arried	. Was Dec Armed For 1 Tes If Yes, Gi Year or E	orces? 2 <b>X</b> No ive		1	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 🛛 No	lispanic Ori an, Mexicar Specify:	n, Puerto	cify Yes or No Rican, etc.)		4. Race - Amen Black, White, Specify: Whit	etc.	
7	"natu	letec	15. Deced (Specify only hig	ent's Educa rest grade d	tion completed)	)		(Give	tent's Usual Occup kind of work done DO NOT use retired	durina mos	st of worki	ng	16b. Kin	d of Business/Ir	ndustry	_
212	filed withir Hygiene. other than	Completed	Elementary/Secondary (0-12 12	)	College (	(1-4or 5+)		Actuar		-/			Monum	ental Ins	surance Co.	
	m - 0 =	Bec	17. Father's Name (First, Midd	e, Last)	· · · · · · · · · · · · · · · · · · ·							(First, Middle,	Maiden S	Surname)		_
Maryland	should be and Mental marked o	<sup>C</sup>	Rudolph Dreyer  19a. Informant's Name/Relation	achia (Tuac	Orine)			105 Mailie	a Addana (Ctana		E Geh		0:5	T Ct 7	- 0-1-)	
	d 2 in all the strain train		Shirley Clark	nsnip (790e	i, riinij				ng Address <i>(Street</i> Erie Avenue			e, Maryla			o Code)	
Baitimore,		100	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		noval from	State	cer	netery, cren	sition (Name of natory or other place emetery Nov	·		oate		ation - City or Ti		_
<u>=</u>	permit. Page Department of Important: if ony injury or once.		21. Sign ture of Funeral Servi	A				The second second second	Name and Addre						) <del></del>	
11	20559		(letter	LBS	ohn		do este		7401 Belai:	r Road	Balti	more, Mai		21236	Approximate	_
	Physician /Medical		23a. Part1. Enter the disease shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)	ist only one	Me	tast	ahic		certo li				rest,		Approximate Interval Between Onset and Death	
	Examiner				Due to	(or as a	conseque	once or):	inknown	prin	nany	- "				
	acuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>d</b> b		(or as a										
8/60,	cate be executed physician and the burial-transit	icai	Tosuming in dodain Last	<b>L</b> d	Due to	(or as a	conseque	ence of):								
O. BOX 6	the death certificate be executed y the attending physician and iched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	230	: If yes, ou 1□Live ( 4□Preg 9□Unkn	birth 2 nant at tir	Fetal d	leath 3	Ectopic pregnancy Other (specify)	/			23	Bd. Date of deliv Month	ery Day Year	
cords, P	law requires that the de as been signed by the a 2 should be detached	þ	Part II. Other significant cond	tions contri	_		not result	ting in the u	nderlying cause giv	en in Part I					he cause of death?	
Ë	The lavate has	Completed										24a. Was autop perfo	rmed?	prior to co death?	opsy findings available impletion of cause of	
VItal	Physician: r this certifica ral director, p	o Be	25. Was case referred to medi examiner?  1 Yes No		spital:	Inpatient	2□ =	P/Outpation	t 3 DOA Oth	00	,	(Check only o				_
lon or	ding Pt J. After th funeral	-	27. Manner of Death 1-☑Natural 5 ☐ Pen	ding stigation	28a. Date (Mor			28b. Time of Injury	28c. Injur Wor		2	28d. Describe h		Other (Special occurred	ry)	-
DIVISION	P Sign	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	d not be mined	28e. Place build	e of Injury ling, etc.	/ - At hom (Specify)	ne, farm, str	eet, factory, office		2	28f. Location (S City or Tox		Number or Run	al Route Number,	-
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical	29a. Certifier 1 Certif (Check only one)	ring Physic al Examine	r: On the b	e best of pasis of e nner state	xamınatıç	ledge, death on and/or in:	occurred at the tirvestigation, in my c	pinion, dea	nd place, a ith occurre	and due to the e	cause(s) a date and p	and manner as s place, and due t	stated. o the cause(s)	
	To T To I	Σ	29b. Signature and title of certi	fier	) -		MD		29c. Licens					signed (Month,	Day, Year)	
	7		30. Name and address of pers		platad	<u> </u>	th (ltc= 2	23a) /T	Print)	1789	>		IV	140		_
10			Głoska Dix	~ MK	)	28		Walt	her Blue	J. Pa	vkvi	ile Mr	2 7	1234		
	Sta Řegistr	10	31. Date filed (Month, Day, Ye		32. F	Registrar'	s Signatu	re	Print) Her Blue	7		1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Margaret Corkran 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Roseda 9. Birthplace (State or Foreign Country) 7,1924 Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Nov • 17 7. Age (In vrs. la **Funeral** Months Days Hours Min 218-12-8708 1 M 2 X F 83 Nov. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at or 28a-f show Middle River 1 ☐ Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 4030 Chestnut Road 21220 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Baltimore Maryland 21215-003 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)

Realtor Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Truszkowski Bertha Dombroska ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4030 Chestnut Rd. Middle River, MD 21220 19a. Informant's Name/Relationship (Type. Print) Lois Corkran/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred HeartofJesus 11/16/07 Dundalk, MD 20a. Method of Disposition 20c. Location - City or Town, State t∏Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Runeral Service License 22. Name and Address of Facility 300 Mace Avenue Balto. MD 21. Signature Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner ointes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,完 attending physician and Due to (or as a consequence of Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ INFavo 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo ٢ 1 TInpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DRENGON GUMBS 9000 Franklin S 9000 Franklin Sq

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

NOV 2 0 2007

3. Registrar's Signature

07-08886 Robert Samu	el C		Sta	oe or Print i	and / Depa	artmen	t of H	lealth an				egib		0.7	31	508
			I- For State Registrar 1. Decedent's Name (First, Middle	a L ant)	Ce	rtificate	of L	eath			2. Date of D	Reg. N	lo. 20		. Time of De	
Phys Medical Exa		-									Month Novemb		y Year	l s	1133 hr	
C.C.			ROBERT SAMUEL  4a. Facility Name (if not institution		umber)		4b.	City, Town, or	Location of	of Death	TTOVETTE		4c. County of E	Death		
- }			1401 Bloomfield Aven	ue Room # 33	1		E	Baltimore					BALTIMO	RE	CITY	
Fune	ral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthda	· ·	If Under 1 Yea		er 24Hrs.	8. Date of		M/DD/YYYY) 9	9. Birthp	lace (State	
Direct	or	- 1	225-19-8106	1 X M 2 F	40		Yrs.	Months Day	/s Hours	Min.	MAY 1	4.	1967	Coun	WASHI	NGTON, DC
	П	į	Usual Residence of Decedent								1414 -					
w any			10a. State 10b. County		10c. City	, Town or L	_ocation							1	0d. Inside (	2 X No
land	once.	ğ		ARUNDEL	PA	SADEN		2.5								2 <u>A</u> NO
7 Mary 7.289	notified at once.	Funeral Director	10e. Street and Number				1	0f. Zip Code				10g. (	Citizen of What	Countr	y?	
th the	notifi		3509 OLD CROWN					21122		: 0 / 0	-'6 )/		ITED ST			
T (	st pe	Je .	11. Marital Status  1 Never Married 2 Ma	arried Armed F	pro-	J.S.   13		Decedent of Hi , specify Cuba				No-	14. Race - A White, e		n Indian, Bi	ack,
er deg	r mu			1 Yes orced If Yes, Give Ye	2 X No		1 V	es 2 X No	specify:				Specify: W	ara ar un.	7	
urs af	mine	q	15. Decedent's Education (Spec	or Dates:			edent's	Usual Occupa	ation (Give	kind of w		161	o. Kind of Busin			
72 hou	al Exs	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)	duri	ng most	t of working life	e. DO NOT	use retir	ed)					
036 ithin i	1edic	du	12			SAL	ES					A	UTOMOTI	VE		
5-0036 iled within 7. Hygiene.	the A		17. Father's Name (First, Middle,	Last)					18.Mother	r's Name	(First, Middl	e, Maid	en Surname)			
121 1 be fil ental F	vent,	a	JOHN WILLIAM C								. BLAC					
D 21 should and Mei	atic	٩	19a. Informant's Name/Relations			1/3	-	,					, City or Town,			
, MD and 2 sho salth and	Tage	H	BRENDA CLARK/ 1 20a. Method of Disposition	MOTHER	20h			NTRAL A		LST E	LOOR;		EN BURN c. Location - C			21061
MOFE, Pages 1 ar	ther	- 1	1 Burial 2 X Cremation	3 Removal f		crematory			,,	NOV	. 21,			.,	,	
timent	010	-	4 Donation 5 Other Sp		ME	TRO C			6 E 100		2007	C.	ATONSVI	LLE	, MAR	YLAND
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien and Maryland Important. If item 27 is marked other than "natural", or items 23a or 28a-f she			21. Signature of Fun ral Service	Licensee			KIRI	ne and Addres	IDDICI	X FUI	NERAL	НОМ	E, P.A.	TD.	21061	
Physici		$\dashv$	23a. Part I. Enter the disease, or	complications that	caused the deat			CRAIN mode of dying					RNIE, M shock, or heart	_	Approxima	te Interval
/Medic		ļ	failure. List only one cause	37	a (horoir	and o	VIICO	dono) C	ocoine	and	alcohol	into	vication		Between 0 De	
amir	er	- 1	Immediate Cause (Final disease or condition resulting in death)		a consequence		хуси	ione), o	Сапе	and	alcolor	шио	AICACIOII	$\neg$		
**			Sequentially list conditions,	b										_		
		xaminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	of):										
		all	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):	_					_		$\dashv$		
executed an and	- transit	шТ		d												
e exec	rial -	ledical	X UNPENDED	AMENDED	27,28a-f,	perME.	o874	12/3/0	7 TT							
Box 68760 e death certificate b	funeral director, page 2 should be detached for use as the burial - tran	/Me	IF FEMALE:	23c. If yes	, outcome of pre	gnancy	<u> 5017</u>	<u>, 12/3/0</u>				T	23d. Date of de			
68 certifi	se as	sician/M	23b. Was decedent pregnant in the past 12 months?	I DAG	birth nant at time of o	2 _ leath =		death 3	Ectopi	ic pregna	incy	İ	Month	Da	У	Year
30X death	for u	ysic	1 Yes 2 No 9 Unit	7		leath 5	Othe	r (Specify)								
at the	tachec	Phy	Part II. Other significant condit	ions contributing	to death but not	resulting in	the unc	derlying cause	given in P	art I.	23e. Di	d tobac	co use contribu	ute to th	e cause of	death?
, P.O. res that th	be de	d b									1	Yes 2	2 No 3	Proba	bly 4 🗸	Jnknown
rds requi	plnou	Completed									24a. W	as an itopsy			psy finding mpletion of	
e law	ge 2 s	힑									pe	erformed s 2	d? de	ath?  Yes	2	No
	or, pa	ပ္မို	25. Was case referred to medica					26.Plac	e of Death	(Check		.5	110	103		
Division of Vital Records, tal or Attending Physician: The law requir and after dealh.	direct	ä	examiner?	Hospital:	Inpatient 2	ER/Outpa	atient 3	_	Other <sub>4</sub>	_	g Home 5	Res	sidence 6	Other:	Scene	
Of No Phy	neral	<b>⊢</b> †	27. Manner of Death	28a. Date	e of Injury th, Day,Year)	28b. Tim	e of Inju	ıry 28c. İnj	ury at Wor	k?	28d. Descri	be how	injury occurred	i		
On endir ath.	the fu	Certification:	1 Natural 5 Pend	ding 11/16	5/2007	unk		1	Yes 2 X	No	unk					
VISI or Att	in by	] <u>i</u>		Stigation	ce of Injury - At		, street,	factory, office	building, e	etc.	28f. Location		et and Number	or Rura	l Route Nu	mber, City
Di pital o	filled	틼	4 Homicide deter	rmined (Specify	Hotel						1401	Bloa	mfield Av	ve. I	Baltimo	re, MD
Host 24 ho	etely i			hysician: To the be												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	completely filled in by the funeral	Medical		miner:On the basis  and manner		and/or inve	stigation				at the time, d					
		Σ	29b. Signature and title of certific	er /	$\cap$			1	se number	r		- 1	d. Date signed	,		)
W.	It		1 Adurt	neelly				0.0	.M.E.				lovember 1	7, 200	) <i>[</i>	
0 000		1	30. Neme and address of person	who completed cau	use of death (Ite	m 23a)		and Western								

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

Laron Locke MD.

31. Date filed (Month, Day, Year)

OCME

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 1 Department of Fiealth and Mental Hygiene

			For State Registrar	State of Ivial	•	ertificate of		R	Reg. No.2	07	36982
E.	Physici	an	1. Decedent's Name (First, Middle, Las Mildred Merlean	<sup>t)</sup> Christian				2. Date of Dea Month Nov. 15	Day	Year	3. Time of Death 6:30 A M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death	NOV. 13		ty of Death	0:30 A
	Examili	eı	14176 Cherry Lane			Queen Ai			Caro		
	Funeral Director		5. Social Security Number 6. Social Security Number 1 242–40–2543 1  Usual Residence of Decedent	9x □ M 2対F 7. Age (	(In yrs. last birtho	Months   Days		8. Date of Birth (Month, Day March	, Year)	Cou	place (State or Foreign ntry) th Carolina
	/land low		10a. State 10b. County		I0c. City, Town o	Location					10d. Inside City Limits
	a-f sh	ctor	Maryland Queen A	line	Queen						1 □ Yes 2 🖾 No
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		
	eath v ns 23a must	Funeral	14165 Cherry Lane	12. Was Decedent Ev	er in U.S.	21657  13. Was Decedent of If Yes, specify Cut	Hispanic Origin? (Spe	ecify Yes or No-	United 14. Ra	d Star	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at once.		1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cut 1 ☐ Yes 2 ☑ No		Rican, etc.)	Speci	ack, White, ify: Wh:	etc. ite
2	72 ho natur dical E	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	1 (6	ecedent's Usual Occu	during most of work	ing [	16b. Kind of 8	3usiness/In	ndustry
121	within ene. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use retire Lemaker	ed)		Own I	-lome	
<b>d</b> 2	filed I Hygi other rent, tl	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,			
/lan	ould be f Mental I arked of	To B	Calvin Robinson				Viola Ha	11			
far)	2 should n and Men is marke raumatic	·	19a. Informant's Name/Relationship (7			ailing Address (Stree					
e,	1 and Health em 27 ither tr		Becky L. Schmidt/ 20a. Method of Disposition	Daugnter	20b. Place of D	76 Cherry sposition (Name of		Date	Mary 20c. Location		
Baltimore, Maryland 21215-0036	it. Pages rtment of l rtant: If Itu njury or o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Signatur) of Funer   Service Liven	)	Crownsv	ille MD Ve	et. Cem.	2007			e, Maryland
Ba	permit. Departr Importa eny Inje		21. Signatura of Fuller Service Etter	K I	}	22. Name and Addr Kirkley-Ru 421 Crain	iddick Fun Hwy., S.E	eral Ho	me, P. <i>A</i> Burnie	4. 2, MD	21061
Ī	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the one cause on each line.	he death. Do not		ing, such as cardiac	or respiratory are			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of)	Congr	,				77(1700)
4	Lammer	Je.	Sequentially list conditions,								
	ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events		conse uence of						
Ó	tificate be executed g physician and as the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of)						
68760,	cate by	edical		.d						-	
Division or Vital Records, P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3 □Ectopic pregnand 5 □ Other (specify)	су			ate of deliv	very Day Year
ds, P.	luires that ( n signed by	by	Part II. Other significant conditions c	ontributing to death but	not resulting in th	e underlying cause g	iven in Part I.	23e. Did to	4.0		the cause of death?
Reco	The law rec te has beel age 2 shou	Completed						24a. Was a autop perfor		prior to co death?	opsy findings available ompletion of cause of
Ita	ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Deat				
٥ ا	Physician: r this certificatal director, I	P	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury		THEIR SELDON		me 5 🖾 Resid			ify)
OU	dIng h. h. After funer	tion:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		ry Wo	ork?	Zod. Describe i	iow injury cook		
Divisi	I or Attending after death. Director: After in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined			, street, factory, office	)	28f. Location (S City or Tow		nber or Rui	ral Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one)  1 ★ Certifying Ph 2 ★ Medical Exam	ysician: To the best of niner: On the basis of earth and manner state	examination and/	leath occurred at the or investigation, in my	time, date and place, opinion, death occur	and due to the cred at the time,	cause(s) and r date and place	nanner as e, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	AV.	110		ise number		29d. Date sigr	ied (Month	, Day, Year)
	/		) = 0	Att.	MD		047531	4 1	Novembe	r 15	, 2007
	5		30. Name and address of person who Wafik Zaki, M.D.,	920 Market	t Street		Maryland	21629			
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	W 10					

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

State

21239

LOPPANE OFORI-ANNAH, MD. 5601 LUCH LAVEN BLVD, BALTIMORE

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 2 0 2007

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** NOVEMBER 15 CALLES 0919 2007 MARGARET /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTEMORE SOHNS HOPKINS BAYVIEW MEDICAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | OCT . 16, 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2**X** F 89 MARYLAND 220-66-0220 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director N/A BALTIMORE MD 10g, Citizen of What Country? 10e. Street and Number 3129 FAIT AVENUE 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ρ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental h 1 and 2 should be NICHOLAS EVERD MARGARET ZEBELINE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Important: If item 27 is r GEORGE MUNDY/ SON 3129 FAIT AVENUE, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 11/19/07 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA **Physician** /Medical Due to (or as a consequence of): **Examiner** RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as E FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by FEBRILLATION 1 Yes 2 No 3 Probably 4 X Unknown page 2 should OBSTRUCTIVE VENTILATORY DEFECT 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEVERE autopsy performed death? 1 ☐ Yes 2 **N**0 2 X No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 npatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 🛮 Natural 5 Pending investigation s after dec.
seral Director; Ar
v filled in by the 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a e Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD RES-001 NOVEMBER 15, 2007 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21224 4940 EASTERN AVENUE PERTI 31. Date filed (Month, Day, Year) NOV 2 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15:50 NOVEMBER 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tospilal mail If Under 24 Hrs. 8. Date of Birth
Hours | Min. (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days **Director** 29, 1957 Nort Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show r 28a-f show notified at 10d. Inside City Limits Noth. Na 1 Yes 2 No Directo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 206 7601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 4 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disable IA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nav ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) alo 27601 Ladop . Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Cemele 11-21-0 4 □ Donation 5 □ Other (Specify) adh 22. Name and Address of Ficility W. R. 21. Signatu of Funeral Service Licenses 23a. Part Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY & SEASE Bacto. md +21229 Approximate Interval Between Onset and Death **Physician** 10 years /Medical Due to (or as a consequence of): Examiner 48 hours PMILURE RESARATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and bunal-transit the death certificate be executed END-STAGE RENAL 10 years Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. □Yes 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an autopsy performed? Yes 2 No certificate has page 2 10 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**X** No Hospital: 1 Nnpatient 2 1 ☐ Yes 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

AT 2438946

UNION MEMORIAL HOSPITAL BALTIMORE

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Segistrar's Signature

ANDREEA OLARU, M.D.

NOV 2 0 2007

31. Date filed (Month, Day, Year)

11/15/2007

MA

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of I rtificate of	lealth and Me Death	ental Hygie Reg.		36986
	Dhusia		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
	Physic /Medi		Catherine	Co.	llins		1	Month Vovembe	Day Year 13 200	7 10:35 pm
	Exami	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Deat	h
			Heritage Nursi			Dunda			BALTIMOR	
L	Funeral Director		5. Social Security Number 6. S 219-01-6761	M 202 F 7. Ag	e (In yrs. last birthday, 89 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye ulv 22	9. Birtl Co 1918 Mar	hplace (State or Foreign untry)
	pu ,		Usual Residence of Decedent  10a, State 10b, County						TOTO Mai	утани
	larylan show	5		0	10c. City, Town or Li					10d. Inside City Limits
	the M	Director	Md. Baltimo	re Co.	Dunda					1 ☐ Yes 2 ☐ No
	with a or	Ö	7232 German Hi	17		10f. Zip Code 21222		10g.	Citizen of What Co	untry?
	Jeath	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13		Hispanic Origin? (Spec	ify Ves or No-	U.S.A.	rican Indian
920	72 hours after death with the Maryland naturel', or flems 23a or 28a-1 show alsal Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Provorced	Amed Forces? 1 ☐ Yes 2 ☑ Il Yes, Give Year or Dates:		If Yes, specify Cubin	an, Mexican, Puerto R Specify:	ican, etc.)	Black, White	
2-0	72 hours "naturef",	eted	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occup	pation	168	o. Kind of Business/l	ndustry
Maryland 21215-0036	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	ife.	ctary / bo			Retail	
<b>d</b> 2	filed Hygi Sther		17. Father's Name (First, Middle, Last)		Beere	cary / bo	18. Mother's Name (	First Middle Mail		
<u>la</u> n		To Be	Harry	Jenkins			Minnio	Loof	flor	
ary	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (Street	and Number or Rural	Route Number, Ci	ity or Town, State, Z	ip Code)
	1 and 2 Health tem 27 a		Sharon Bailey (da	aughter)	621	3o11 Weev	il Circle#1	6-228 Ent	erprise, Al	labama
Baltimore,	Section		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place of Dispo	sition (Name of matory or other plac	Da		. Location - City or 1	
Iţir	교문문을 .		4 □ Donation 5 □ Other (Specify  21. Sign № re ■ Funeral Service Licen:				tery 11/			
Ba	Depa Impo eny fi		Januar 3	ameroc	ushi 40	01 Ritc	<sup>ss ol Facilit</sup> Gonc hie Hwy.	Balto.	Md. 212	
			232. Part1. Enter the disease of composhock, or heart failure. List enty of	lications that caused one cause on each lin	the death. Do not ent	er the mode of dyin	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a COYON	ARY A, a consequence of):	RTERY	DISER	5E		Onset and Death
	Examiner		- 1							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as	TES M	- 6470				
/	cuted nd ransil	Examin	that initiated events	· PERIPA	ERAL D a consequence ol):	ASTULI	AR DISC	EAKE		
ő	e exe ien a urial-l	EX	resulting in death) Last							
68760,	ficate be executed physicien and ts the burial-transit	edicai	•	d. HYPE	RIEN510	ON				
9 ×	ding p	/Me	IF FEMALE:	220 16 1100 01100	-4					
P.O. Box	The law requires that the death certing the best perting the been signed by the ettending bage 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 PNo 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delik Month	<b>rery</b> Day Year
ري ت	s that	by P	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ž	equire en sig ould b	ted t						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
Vital Records,	The law rie hes be age 2 sh	Completed						24a. Was an autopsy performed	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
		0	25. Was case referred to medical			The second	26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 No
<u>&gt;</u>	Physic this ce al direc	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	3□ DOA Othe	ar /		6 ☐Other (Speci	fv)
Division of	Attending Physicien: r death. ector: After this certifice by the funeral director, I		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work		d. Describe how in		97
Divis	To the Hospital or Attending Phywithin 24 hours eller death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, eld	ry - At home, larm, stre . (Specify)	eet, lactory, office	28	Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or At within 24 hours eller of To the Funeral Direct completely filled in by	edicai (	29a. Certifier 1 To ertifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	f my knowledge death examination and/or inv	occurred at the timestigation, in my op	e, date and place, and pinion, death occurred	I due to the cause at the time, date a	(s) and manner as a and place, and due t	stated. to the cause(s)
	No the		29b. Signature and title of certifier	W. C. H. C. H. C. C. C. C. C. C. C. C. C. C. C. C. C.	iod.	29c. License	a number	29d. I	Date signed (Month,	Day, Year)
)			Mariadu 10	Tinle	MID	175	27186		11/14/m	7
	9		30 Name and address of person who co	ompleted cause of de	eath (Item 23a) (Type, I	Print)	27188 Dienslatte	MI	2/222	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	o lall	) worskert	- (4/1)	4212	
	Registra	_	NOV 2 0 200		He Ange	A 8				

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland / Department of Health and Maryland / Department of Death		en2 0 0 7	36987
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Yeer	3. Time of Death
	/Medi	cal	Catherine R Coffey	Nou	7 2057	
	Examir	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Balhoni 9. Bii	thplace (State or Foreign
	Director		212-20-7924 1 M 2 NF 83 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, June 23,	1924 Mar	yland
	puq *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Aarylis f sho	ō	MD Baltimore Parkville			1 Yes Y No
	28e-	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	
	h with		2904 Garnett Road 21234		USA	
	hours after death with the Maryland turel', or Items 23e or 28e-f show all Examiner must be notified	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Am Black, Whi	
9	or It	by Fu	1 □ Never Married 2 ☑ Married 1 □ Yes ② □ No If Yes, Give 1 □ Yes 2 ☑ No Specify:	o i ttoditi, oto.,	Specify: wh	
21215-0036	ture		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation	1.	6b. Kind of Business	
515	s filed within 72 h I Hygiene. other then "netrent'ent, I is Medica	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)	king		
7	giene giene er the	Com	Elementary/Secondary (0-12) College (1-4or 5+)  12 Machine Shop Operato	or L	ever Brotl	ners
yland		Be		ne (First, Middle, M		
<u>\S</u>	ould Men arke	10	Craude Landra Crauteria	e Leona M		
Mar	d 2 s th ar 7 is treu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rur  George Coffey—spouse  2904 Garnett Road—Parky		•	
	s 1 and if Health item 27 other to		20a Mathod of Disposition 20b. Place of Disposition (Name of		oc. Location - City or	
aitimore,	permit. Pages Department of I Importent: If ite any injury or of once.		1 X Burial 2 Cremation 3 Removal from State Bel Air Memorial Caroers Nov. 20		el Air,M	
	permit. P Departm Importer any injui		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	8800 H	arford Ro	ad
ñ	P P C C C		Condal M. Jasto AND CREMATION SERVICE	Parkvi	lle,Maryl	and 21234
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	it,	Interval Between
Ň	Pnysician		Immediate Cause (Final disease or condition Renal Failure			Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
1	uted d ansit	Examine	cause. Enter Underlying Cause Cuses of Highly that initiated events  c.			
ĵ	an an		resulting in death) Last  Due to (or as a consequence of):			
0/0	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d			
õ ×	ertific ling pl	00	IF FEMALE:			
X D D	that the death certifii ed by the attending p detached for use as	ian/M	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de Month	livery Day Year
j	the de	hysici	1 ☐ Yes 2√2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown			
7	w requires that the been signed by the should be detach	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	o the cause of death?
Hecords	quire:		a. fib	1 ☐ Yes	2 <b>X</b> № 3 🗆 P	robably 4 Unknown
) ၁	law re as bee	ompleted	PSCOD	24a. Was an	24b. Were a	utopsy findings available
		Com		autopsy performe	ed? death?	completion of cause of
VII	ysicien: is certific director,	Be (	examiner?	th (Check only one)		
5	Physi this c	T0	1 ☐ Yes 2 🖪 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Cther: 4 🗷 Nursing Ho  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ocify)
5	ding I h. After funer	Certification:	1 KNatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	injury occurred	
VISION	Attendii r death. sctor: A by the fu	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre	et and Number or R	ural Route Number,
5	s after	Certi	4 Homicide determined building, etc. (Specify)	City or Town,	State)	
	To the Hospitel or Attending Physicien: within 24 hours after death of the Funerel Director. After this certification is the funerel birector, after the funeral director, completely filled in by the funeral director,	edical (	29a. Certifier (Check only (Ch	and due to the cau	se(s) and manner a	s stated.
	the H nin 24 the F nplete	Medi	one) and manner stated.			
	T MIN O	~	29b. Signature and title of certifier 29c. License number	290	J. Date signed (Moni	n, Day, Year)
	(0)		Wind xloy no ) 329,		11/19/07	
	(0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wendy Klursz G 701 Al Cholds St 3014 4202 70  31. Date filed (Month, Day, Year)  NOV 2 0 2007  32. Registrar's Signature	uwsa-	md s	124
	Sta	te	31. Date filed (Month, Day, Year) 32 Hegistrar's Signature			,,,,,
	Registr	ar	NOV 2 0 2007 Januar Dr Sporter			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2007 November /Medical Town, or Location of Death County of Death Examiner BAUNION Medical Conter Paltimorc Daltimorc If Under 1 Year If Under 24 Hrs Months Days Hours Min. Date of Birth **Funeral** Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location od. Inside City Limits show notified 1 ☐ Yes 2 🛂 No Director 28a-f Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 21921 8 Willow Court Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No White 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ANN 21921 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee aczorows Z3a. Part1. Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hel in failure. List only one cause on each line.

Immediate Cause (First disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death Extreme **Physician** MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter on Jerrying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No certificate 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ No **M**Inpatient 2 ER/Outpatient 3 DOA this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 28c. 28d. Describe how injury occurred Injury at Work? To the Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

NOV 2 0

2007

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Hmore, MD

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36989 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8/0 2007 IRGINIA 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Pasadena Inder 1 Year | If Under 24 Hrs. | Anne Arundel 352 Hunner Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days Min. Hours Months 1 M 2 June 3,1913 582-01-1310 94 Puerto Rico Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 352 Hunner Road 21122 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1∰Yes 2□No Specify: Puerto Rican Specify: Puerto Rican 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 9 N/ASelf Employed Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Felix Estefania DeJesus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 352 Hunner Road Pasadena, Maryland 21122 Dorcas E. Vancil (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Salinas, Puerto Rico</u> Municipal Cemetery 11/24/07 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) 4 Ren Due to (or as a consequence of): Den Due to (or as a consequence of): Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a, State

**Funeral** 

Director

Itame 23s or 28s-1 show

ŏ

'naturel'

al Hygiana.

t of Haaith and Mantal Hyg If item 27 Is marked otha or other traumatic event,

permit. Pagi Dapartment Importent: I any Injury o

the Medical Examiner must be notified at

Completed by Funeral Director

Be ဂ္

Pagas 1 and 2 should be filad within 72 hours aftar death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner physician and the burial-transit use as tha attanding p signad b Completed by paga 2 should diractor, Be ٩ Aftar thi Medical Certification: To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completaly filled in by the fu

or Attending Physician: The law requires that the death cartificate be axecuted

this

daath.

Box 68760,

Division of Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 4☐Pregnant at time of death

9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

24a. Was an

23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown

autopsy performed 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy lindings available prior to completion of cause of death? 1 ☐ Yes

Day

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Duy 0

5 ☐ Pending

29d. Date signed (Month, Day, Year)

no completed cause of death (Item 23a) (Type Print) me and address of person DEFENSE

DAMYY 1 CH AEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

			for State Registrer	State of	of Marylan	•	rtment of		Mental Hyg	iene 9. No. 2 0	07	36990
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Dav	Year	3. Time of Death
	Physicia /Medic		Helen Deal						Novembe	r 9', 2	007	5:33 PM ™
	Examin		4a. Facility Name (If not institution,		imber)			or Location of Dea	th	4c. Count	y of Death	1
			2111 Tucker Lar		7 4 //-	to an factorial also h	Balt If Under 1 Year	imore	Date of Dirth	<u></u>	O Dieth	place (State or Foreign
	Funeral		5. Social Security Numberunk	1. Sex 1  M 2	7. Age (In yrs. 86	Yrs.	Months Days			Year)	Cor	yland
	Director		Usual Residence of Decedent		00				Aug 20,	1921	Hal	y Land
	Now #		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
:	Mar.	to	MD			Balt	imore					1 Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of		untry?
	238		2111 Tucker L					21207		US		
-	tems ferm	Funeral	11. Marital Status	Armed F		.S. 13. \	Was Decedent of Yes, specify Cul	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ice - Amer ack, White	rican Indian, o, etc.
9	within 72 nours after death with the maryland one.  9ne.  Than "neturel", or items 23a or 28a-f show than "medicel Examiner front be notified at	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	d 1 ∐ Yes If Yes, G Year or D	2 🛣 No ive Dates:		l∐Yes 2∏∏ No	Specify:		Speci	ify:	white
3	of ture	ed	15. Decedent's			16a. Deced	lent's Usual Occu	upation		16b. Kind of E	Business/I	ndustry
<u>က</u>	Medical	Completed	(Specify only highest Elementary/Secondary (0-12)		) (1-4or 5+)	(Give	kind of work done OO NOT use retir	e during most of wo red)	orking			
7	than the	mo;	12	2		hea	ring ass					rity adm
פ	be filed within 72 hours after death with the marylar Hydione. At Hydione, and other than "neturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at	ВеС	17. Father's Name (First, Middle, L.						me (First, Middle, I		me)	
<u>a</u>	Mente Mente arked	은	James Edward	Deal Jr					Carolyn C			
<u>a</u>	s 1 and 2 should be in if Health and Mental b item 27 is marked of other treumetic ever	(1)	19a. Informant's Name/Relationshi						lural Route Number Road Will			
2 ()	and ealth m 27		Carolyn Supp/s	istei	20h I		sition (Name of	ean Olly		20c. Location		
Baltimore, Maryland 21215-0036	permit. Pages 1 Depertment of H Important: if ite eny injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State (	cemetery, crer	natory or other pi	ace)	53.5	200. 200211011	0.1, 0.	, , , , , , , , , , , , , , , , , , , ,
	rtmer rtant njury		4 □Donation 5 ☑ Other (Special)			22	Name and Add	ress of Facility				
Ba	Deperiment of the population o		21. Signature of Funeral Service Line Conald S	. Wade	Directo	1			d 655 W.	Baltin	nore	Street
			23a. Part1. Enter the disease, or o	omplications that	caused the deal	th. Do not ent	altimore er the mode of dy	, MD 212 ying, such as cardia	ac or respiratory arr	est,		Approximate Interval Between
	Nh i a i a a		shock, or heart failure. List o Immediate Cause (Final			1 -	) h	.7 7				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a consec	uence of):	Mar He	es; Just				Ore hour
	Examiner		A CONTRACT AND A CONTRACT CO.	N	vpert.	hsivi	$\sim$				+	Tenyeers
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Oue	( as a consec	quence of):						
	icuted nd Iransi	Examin	that initiated events	с.							_	
ő	ate be executed hysicien end the burial-transit	Ä	resulting in death) Last	Due to	o (or as a consec	quence of):						
		dicai		d		-			_			
e X	The law requires that the death certific lie hes been signed by the ettending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If ves. or	utcome of pregn	ancy				23d D	ate of deli	verv
Вох	eath e	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	aldeath 3[	Ectopic pregnant Other (specify)	icy			fonth	Day Year
o.	the d	ysi	1 ☐ Yes 2. ☐ No 9 ☐ Unknown	9□ Unk	nown							
g.	res that the de iigned by the e be detached f	by Pt	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	nderlying cause o	given in Part I.	23e. Did to	bacco use co	ntribute to	the cause of death?
5	w requires been sig should by	P P							1 □ Y	es 2/2 No	3 □ Pr	obably 4 Unknown
ပ္သ	aw re is bee 2 sho	Completed							24a. Was a		. Were au	itopsy findings available completion of cause of
æ	The lav	E O							perfor	med? 2 🗷 No	death? 1 ☐ Yes	4
<u>ra</u>	ien: ortifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of D	eath (Check only or	<i>-</i>		
<u>~</u>	hysic his ce I dire	은	1 ☐ Yes 2 Ø No			ER/Outpatier	II 3 DOA		Home 5 Reside			cify)
Ē	Attending Physicien: It death. ector: After this certification in the funeral director.		27. Manner of Death 1 ØNatural 5 ☐ Pending		e of Injury onth, Day Year)	28b. Time o Injury	W		28d. Describe h	ow injury occu	urred	
<u>s</u>	tendi leath tor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could no	ot bo	a of laive. At h			☐Yes 2☐No	28f Location (S	troot and Nun	nher or Ri	ural Route Number,
	lor At efter d Direct lin by	Certification:	4 Homicide determine	288. Plac	ding, etc. (Spec	ify)	eet, factory, offic	ө	City or Town		nber or At	arar noute rumber.
_	pital ours cours erei	2	29a. Certifier 1 Certifying	Physicien: To the	ne best of my kn	owledge, deat	h occurred at the	time, date and pla	e, and due to the c	ause(s) and r	nanner as	s stated.
	To the Hospital or Attending Physicien: The within 24 hours elter death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai		xaminer: On the					curred at the time, d			
	To th within To th comp	Z	29b. Signature and title of certifle	$\wedge$				nse number		9d. Date sign		
			111111	1 m	0		103	7928	/	Vovem.	ben 16	7 200
			30. Name and address of person y	no completed car	use of death (Ite	m 23a) (Type,	Print)	0	- X 21	0	1 -	- MO21213
			31. Date filed (Month, Day, Year)	The pure	フレ/フ3 Registrar's Sign	W. K.	wheke	/ Venve.	Suile 22	15-1	mon	211071313
	Sta Regist	ate rar	NOV 2 0 20	07	Registrar's Sign		D					

			1- For State of Maryland / Dep	ertificate of Death	_	2007 36991	
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month		
1.5	Physici /Medio		Barbara Jean DelBello		Novembe	10 11	à
100	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	th	4c. County of Death	
-	Funeral	م	102 N. Crain Hgwy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Glen Burnie  If Under 1 Year   If Under 24 Hrs	8. Date of Birth	An ne Ar undel Co.	
	Director		215-42-9767 <sup>1 M 2</sup> F 61 Yrs.	Months Days Hours Min	Month, Day, 1 Dec 7, 1		•
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits	
	Maryla f sho ied at	tor	Md. Anne Arundel Co. Glen Bu			1 □Yes 2 12 No	
	r 28a-	irec	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?	_
	th wit 23a o ust be	Funeral Director	102N.Crain Hgwy.	21061		U.S.A.	
	er deg items ner m	nne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent Ever in U.S.	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- no Rican, etc.)	14. Race - American Indian, Black, White, etc.	
36	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates;	1 ☐ Yes 2 ☑ No Specify:		Specify: White	
21215-0036	72 hou natura Ilcal E	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation	16	6b. Kind of Business/Industry	
2	vithin ne.	mple	College (1-40r 5+)	e kind of work done during most of wo DO NOT use retired)	rking	N/A	
7 0	filed w Hygie ther ti	S	12 nor	ne / disabled	me (First, Middle, Ma		
Maryland	should be f and Mental I s marked of	To Be	Carrol Wolf			Gamber	
ary	2 shou and N is mar	-		ng Address (Street and Number or F		City or Town, State, Zip Code)	
∑ (v̂	and and m 27 m 27 her tr		Jeff Swift (son) 1004		en Burnie,		
or B	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		T Danial 2 Commation 3 Intelligration 3 Late	osition (Name of matory or other place)		Oc. Location - City or Town, State	
Baltimore,	artmer artmer ortant injury					Baltimore, Md.	
Ba	Dep any		Cla Sali and aller	001 Ritchie Hgwy		ral Service P.A.	
			23a P n1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				_
	Physician		Immediate Cause (Final disease or condition and disease or condition an			Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			12.7	Т
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				_
/	ecuted nd transit	Examiner	that initiated events				
9	rificate be executed g physician and as the burial-transit	E	resulting in death) Last  Due to (or as a consequence of):				
68760,	tificate ig physi as the l	edical	d				_
X Q Q	h certi ending use a		IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal death 3			23d. Date of delivery	
	e deat he atte	Physician/N	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>		Month Day Year	
J.	that the		9 ☐ Unknown*  Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e Did toba	cco use contribute to the cause of death?	-
Kecords,	w requires that the death cer been signed by the attendin should be detached for use	d by	Severe Disc disease of the lumbosa		1 ☑ Yes		
<del>ပြ</del>	s beel	ompleted	Convulore seizure		24a. Was an	24b. Were autopsy findings available	_
	sician: The law certificate has b irector, page 2 sh	mo			autopsy performe 1∐ Yes 2 <b>5</b>	prior to completion of cause of	
VITai	ysician: iis certific director,	Be C	25. Was case referred to medical examiner?		ath (Check only one)	2.0	_
0	this ald	၉	Hospital: 1 Inpatient 2 ER/Outpatie 27. Nanper of Death 28a, Date of Injury 28b, Time of			ce 6 Other (Specify)	
0	Attending Physic death. ector: After this by the funeral di	ţi	Natural 5 Pending (Month, Day Year) 2 Accident investigation	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
JIVISION	Atter	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre- City or Town,	et and Number or Rural Route Number,	571
5	urs afte						
	Hosp 24 hou Fune etely fi	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and plac exestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner as stated. e and place, and due to the cause(s)	
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: A completely filled in by the fr	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)	_
			Me - audieno	D/2901		11/18/67	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type,		1).		_
	\ 	0	31. Date filed (Month, Day, Year)  32. Registrar's Signature	leysville Road	Hampste	ad. MD 21074	_
	Sta Registra		NOV 2 0 2007 / See A	aster .	•		

Amend #10ex19b, per DVR, 9873, 11/20/07 TI State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 10e&19b, perFH, g873, 11/20/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Thomas Louis D'Angelo /Medical 5:20 p November 13, 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove Hospice House Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Days Hours Min 1**X**M 2∏F 140-24-1950 76 Director March 14, 1931 **New Jersey** Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 □Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 6534 Beechwood Drive 10f. Zip Code 10g. Citizen of What Country? ō 6534 Beechwood Drive 21046 items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Nental Hygiene. 1 Never Married 2 Married "natural", or Maryland 21215-0036 2 No 1 🗆 Yes Specify. þ 1952 1956 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Engineer University Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George D'Angelo Angela Ottomano မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5554 Beechwood Drive Columbia, Maryland 21046 permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra Ms. Prudence Y.D. D'Angelo Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Ocremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State All County Cremation Services, Inc. 11/18/07 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. MO0535 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. It only one cause on each line. 23a Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Orse and Death mediate Cause (Final ease or condition sulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a ponsequence off Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 No. 1∐ Yes 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 **1** No Certification: To 1 Tyes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital hours the Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within To the 29b. Signature ar 29c. License number tle of certifier 29d. Date signed (Month, Day, Year) 20 30. Name and add ess of person who comp ted cause of death (Item 23a) (Type, Print) Street Westminster, MD21157 XULT CENTER

istrar's Signature Registrar's State 0 2 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marjorie Earnest Ann Nov 16. 11:56 A<sup>M</sup> /Medical 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) June 20, 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 Davs Hours Director 231 36 9025 Usual Residence of Decedent Washington DC a or 28a-f show be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examiner must be n 8500 Mike Shapiro Drive #810 20735 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 👿 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Colin Campbell Gertrude Mae Talbert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5902 Mt. Eagle Drive #818, Alexandria, Va 22303 Donna Coleman (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov 21. Date 2007 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Furial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park Falls Church, Virginia 21. Sign ture of Funer I Saulo Leensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d M00257 Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute **Physician** /Medical Due to (or as a consequence of): Examiner DOILY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or all a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy łō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 hyperlipidimia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) NOV. 17, 2007 9135 PISTATAWAY Rd. #310 CLINTON, MD 20735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BASIR MOITMAD FROLER MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 0 Frank Stant Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 4:50 AM M October 28, 2007 Roberta Ann Elliott /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Forest Glen Nursing & Rehab Silver Spring Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛱 F 62 Washington DC Director 213-44-6421 May 9, 1945 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itam 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic event, the Nedical Examinar must be notified at 1 Yes 2 No Director Prince George's Forestville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20747 2706 Kirtland AVenue permit. Pages 1 and 2 should be filed within 72 hours after deat Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural". or Itam any injury or other traumatic even. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 grounds worker 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Rosa Hollis Roland John Crismond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18540 Heritage Hills Drive Olney, MD 20832 Roland Crismond/brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street Difestor 21201 25a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MĎ Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mknocon **Physician** Lung ancen /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transit The law requires that the death certificate be executed attending physiclan and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 20 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been sig r, page 2 should b rachcostomy Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has Weight 1 ☐ Yes 2 X No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide determined filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year) 2 Chow dly D43121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE; BURTONSVILLE, MD 20866 NURUL CHOWDHURY, MD; 15216 DINO . Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 0 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Ö Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ZACHARY TAYLOR EVERETT November 17, 2007 2:47 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OAK CREST VILLAGE Parkville Parkville Baltimore County If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept 12, 1924 Birthplace (State or Foreign Country) **Funeral** 1∏ M 2□ F 314-20-6930 Director 83 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show be notified at 10d, Inside City Limits 1 ☐ Yes 2 No Directo Maryland | Baltimore County Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be 8820 Walther Boulevard 21234 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 N Yes 2 No 43-65 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036( 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Vice President Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larkin Everett Nora Shouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If Item 27 is any injury or other trau Mrs. Gudrun J. Everett (Wife) 8820 Walther Blvd, Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 11/20/2007 Baltimore, Maryland 21. Signature of Funoral Service Consession Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 awson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician stage /Medical Examiner Sequentially list conditions, if any learn 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) o the signed by t I be detach σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 21 No 1 ☐ Yes 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28d. Describe how injury occurred Medical Certification: Division Hospital or Attending 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: , I in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in by hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Blud, Parhville MD 8800 Walthor Dixon M 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar NOV 2 0 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 36996

		For State	Ce	rtificate of	Death			. No.	
Physician Jedical Examine	/ 1 er	. Decedent's Name (First, Middle,Last) He16	en E. Eber				2. Date of Death Month I November	Day Year 14, 2007	3. Time of Death 1835 hrs
	4	a. Facility Name (if not institution, give street and 110 13th Avenue	and number)	4	b. City, Town, or Lo Brooklyn Parl			4c. County of Dea	
Funeral Director	5	5. Social Security Number 6. Sex 228 12 1115	7. Age (in yrs.	last birthday) Yrs.	If Under 1 Year  Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. E Fore	sirthplace (State or sign sountry)∛irginia
215-0036 be filed within 72 hours after death with 1 ntal Hygiene. rked other than "natural", or items 23s on, the Medical Examiner must be not	lo Be Completed by Funeral Director	Javal Residence of Decedent  Joa. State  Job. County  Anne Arund  Joe. Street and Number  110 - 13th Avenue  Joe. Street and Number  110 - 13th Avenue  Joe Married  Joe Marri	as Decedent Ever in med Forces? Yes 2 X No live Year st grade completed) lege (1-4 or 5+)  DMAS Sager Int ) Son	16a. Deceden during m Hon 19b. Mailing 12 - D. Place of Disposerematory or other dar Hill 22. N	Per 10f. Zip Code 21225 s Decedent of Hispases, specify Cuban, I Yes 2 X No 1's Usual Occupation cost of working life. In the Marker 1 St Avenual ition (Name of cemer place) 1 Cemeter lame and Address of the st	Mexican, Puerto I specify:  In (Give kind of wood NOT use retired Net 11 and Number or Face Basetery, 11/of Facility Go	ecify Yes or No-Rican, etc.)  ork done ed)  (First, Middle, M. ie May I tural Route Numl I timore, Date  19/2007	White, etc.  Specify: When the specify with the specify with the specify with the specify with the specify with the specify with the specific with the speci	erican Indian, Black,  nite s/Industry  Iome  ate, Zip Code) 21225 or Town, State  re, Maryland  Ce. P.A.
Physician (Medical :aminer		or condition resulting in death)  Due to  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	and Neck Injurie for as a consequence	th. Do not enter t es complicati e of):	he mode of dying, s	uch as cardiac o	r respiratory arre	st, shock, or heart	ry1and 21225 Approximate Interval Between Onset and Death
be executed sician and burial - transit	Exa	events resulting in death) Last  Due to	or as a consequence	e of):					
76 icate		IF FEMALE: 23c.	If yes, outcome of pr Live birth Pregnant at time of Unknown	2 Fe	etal death 3 [ther (Specify)	Ectopic pregna	ancy	23d. Date of delive	very Day Year
P.O. Eres that the disigned by the	<u>a</u>	Part II. Other significant conditions contril	outing to death but no	t resulting in the	underlying cause gi	ven in Part I.			to the cause of death?  Probably 4  Unknown
Division of Vital Records, P.O. Box 68 not the Hospital or Attending Physician: The law requires that the death certify to the Funcral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Completed						24a. Was a autop perfor 1 <b>V</b> Yes	sy prior rmed? death	
ital Recition: The sector, page	Be	25. Was case referred to medical examiner? Hospita	: 1 Inpatient 2	ER/Outpatien		of Death (Check Other Nursin		Residence 6 ✔ 0	ther: Scene
ion of V tending Phys eath tor: After thii the funeral di	ation: To	1 Natural 5 Pending	a. Date of Injury (Month, Day, Year) OUND:	28b. Time of FOUND: 1820 hrs	Injury 28c. Injur	y at Work? es 2 ✔ No	28d. Describe I Subject fell	now injury occurred	
Division To the Hospital or Attend within 24 hours after death To the Funeral Directors completely filled in by the	Certification:	3 Suicide 6 Could not be determined (	Be. Place of Injury - A Specify) Single F	amily Home			or Town, S 110 13th Aver	state) nue, Brooklyn Parl	
Di To the Hospital within 24 hours a To the Funeral	Medical	29a. Certifier 1 Certifying Physician: To cone) 2 Medical Examiner: On the and m	the best of my knowled basis of examination anner stated.	ledge, death occu n and/or investiga	irred at the time, da	te and place, and death occurred	d due to the caus at the time, date	and place, and due t	o the cause(s)
	ğ	29b. Signature and title of certifier			29c. License O.C.N			29d. Date signed November 15	
W		30. Name and address of person who comple Ana Rubio MD. Assistant Me	ted cause of death (If dical Examiner	tem 23a) 111 Penn	Street, Baltimo	re, MD 2120	1		
Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Sigr	nature	wie s				
DHMH 17 Rev 1/20		NOV 3 0 5001	The state of the s	ORIGINA	AL.				

Toeran Thomas Edon State of Maryland / Department of Health and Mental Hygiene  1-For State  Certificate of Death  Reg No. 2007 3699			
Physician/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	9.140.
Medical Examiner	Toeran Thomas Edon	Month November	Day Year Octob
4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death			4c. County of Death
2510 Edfeldt Drive District Heights Prince George			rince George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		h(MM/DD/YYYY) 9. Birthplace (State or
Director	579-68-8616 1XM 2 F 56 Yrs.	Months Days Hours Min.	Foreign Country) MI
-	Usual Residence of Decedent	1 1 12/19/	1950 [ 111
any	10a. State 10b. County 10c. City, Town or Location	on	10d. Inside City Limits
show	DC Washingto	n	1 Yes 2 No
Maryland -28a-f sh. ed at once	10e. Street and Number	10f. Zip Code 10	g. Citizen of What Country?
the Na or Stiffied	3216 8TH St., NE	20017	T S A
r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,
er death	1 Never Married 2 Married Armed Forces? If Ye 12 Yes 2 No	es, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
s after inal", o	3 Widowed 4 X Divorced If Yes, Give Year 1 9 70 - 1 9 7 \$ 1 or Dates:	Yes 2X No specify:	Specify: Black
natur Ed b	during mo	's Usual Occupation (Give kind of work done ost of working life, DO NOT use retired)	16b. Kind of Business/Industry
s6 n 72 nan " ical l	Elementary/Secondary (0-12) College (1-4 or 5+)		
5-0036 lied within 72 hour Hygiene. the Medical Exam	2+ Home  17. Father's Name (First, Middle, Last)	Improvement 18. Mother's Name (First, Middle, M	Private
215- be filed mtal Hyg rrked of ent, the			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sht injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Tohn Wesley Edon  19a. nformant's Name/Relationship (Type, Print)  19b. Mailing	Fannie Mae Tho Address (Street and Number or Rural Route Num	DMaS ber, City or Town, State, Zip Code)
MD d 2 sho Ith and n 27 is numation	1 55	8th St. NE Washingto	1.0
e, N I and Health item	20a. Method of Disposition 20b. Place of Disposi	tion (Name of cemetery, Date	20c. Location - City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite Important: If ite Injury or other to	1 Burial 2 Cremation 3 Removal from State crematory or oth	· · · ·	
Itin	4 Donation 5 Other Specify: Glenwood 21/Signature of Funeral Service Licensee 22. N	l Cemetery 11/21/200 ame and Address of Facility Ronald Ta	Vor It Tuneral Hm
Ba Perm Dep Imp		B West North Ave.Bal	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate International Control of the Contro			est, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a, Gunshot wounds (2) to head  Death  Death		
( taminer	or condition resulting in death)  Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Due to (or as a consequence of):  Consequence of the sequence of		
ted msit			
x x z z	(Disease or injury that initiated bue to (or as a consequence of):  Due to (or as a consequence of):		
o,  be executed sician and ourial - transit edical Ex			
0, be execut sician and burial - tra	UNPENDED X AMENDED, perME, g873, 11/26/07 TT		
68760 certificate rding phy se as the b	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery  Month Day Year
c 68	past 12 months?	al death 3Ectopic pregnancy  ner (Specify)	Month Day Teal
Box 68760, re death certificate be execut the attending physician and the for use as the burial - training thysician my hysician my hybrit	1 Yes 2 No 9 Unknown 9 Unknown		
O. Be hat the deed by the setached for y Physics	1 Yes 2 No 3 Probably 4 Unknown		
cords, P.O. law requires that the has been signed by 2.2 should be detach or pleted by P.D.			
cords, law requir has been s 2 should t		24a. Was a autop	
Records,  The law requires frate has been signage 2 should be	1	perfor	med? death?
Vital Rec ysician: The I his certificate I director, page	25. Was case referred to medical	26.Place of Death (Check only one)	
Vital hysician this certi	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: Nursing Home 5	Residence 6 Other: Scene
n of ling Ph	27 Manner of Death 28a, Date of Injury 28b, Time of Ir		now injury occurred
tendir	1 Natural 5 Pending FOUND: POUND: Nov 14, 2007 0945 hrs	1 Yes 2 ✓ No Subject sho	
The law required to medical examiner?  In particular in pa			Street and Number or Rural Route Number, City
Dital Disabled Control	4 Momicide determined (Specify) Single Family	or Town, S 2510 Edfeldt I	Drive, District Heights, MD
To the Ho within 24 To the Fu completel	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Salar A Me of Ms	O.C.M.E.	November 15, 2007
	Storing of		
2+1	30. Name and address of person who completed cause of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		
State 31. Date filed (Month, Day, Year) 32. Jegistrar's Signature			
PHMH 17 Rev 1/2001			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:00 a M Charles Bruce Falkenberg Nov. 18, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Copperidge Sykesville Carrol1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 XM 2 ☐ F Director 216-09-9880 89 16, 1918 Maryland Jan. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20 W Chestnut Hill Lane 21136 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 Married 1941-Baltimore, Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 1945 Completed or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other through injury or other traumation. 12 Purchasing Manager MDGlass Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles J. Falkenberg Norah R. McGuire 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Gloria M. Falkenberg 20 W Chestnut Hill Lane Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 11/21/07 Woodlawn, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Line Eline Funeral Home Reisterstown, MD 21136 >auss 20a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm viate Cause (Final se or condition resulting in death) Atheroscieruh Carchivascal **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence on sician and burial-transit certificate be executed Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate | 1☐ Yes 2☑ No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Road Westministe MD 21157 tmoon 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36999 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Helen Agnes Fowler 2:30 AM November 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F Months 85 217-12-5420 November 7, 1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Maryland Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 Spring 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esteile John Welsh Laby S 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Spring Ave. Lutherville, MD 21093 Husband Thomas Fowler, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry November 15,2007 Hanover, MD 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 1522 Connelley Drive Ste. P Nanover, MB 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) STOKE and week Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

ဂ္

**Funeral** 

Director

show

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-transit and physician Physician/Medical attending properties

2 page 2 should Completed director, Be Certification: To funeral

O

Division or Vital Hospital or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

performe

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ⊡•Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29a. Certifier (Check only one)

NOV 2

0

1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number 1)25205

29d. Date signed (Month, Day, Year) November 16, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Balto. Md Zi 20% 6 Bmc 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

after death Director:

To the l within 2, To the l

filled in by

completely

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 16a b per fth 8875 1-3-08 vt. State of Maryland Prepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Carl J. Fleagle NOVEMBER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year 6. Sex **Funeral** Days Hours 1 ☑ M 2 □ F 96 215-07-0573 Jan. 8,1911 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f shov must be notified at 1 ☐ Yes 🗶 No Baltimore Towson Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Southerly Road 21286 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Oil Company Elementary/Secondary (0-12) College (1-4or 5+) <u> Cransportation</u> Coordinator Tool & Die Make 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Duvall Archie Casper Fleagle ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stephen Fleagle 5326 Dogwood Road, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/21/2007 Catonsville, Maryland 4 □ Donatjon Metro Crematory 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOCK /Medical Due to (or as a consequence of) **Examiner** CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician; The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by DEMENTIA 2200 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No nis certificate has director, page 2 s autopsy 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 00 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Deal Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier Wiella mo 1200 D41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. M. D. 76 01 32 Jegistrar's Signature JOGINDER MEHTA 7601 OSLER DRIVE TOWSON, MARYLAND 21204

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 2 0